FRAMING QUALITY

Constructions of medical quality in Swiss family medicine

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The picture on the title page was taken at a demonstration of family physicians in front of the Federal Palace on 1 April 2011 [photo by the author]. The banners shown in this picture ("Am I the last family physician?" and "Family-medicine quality instead of mass treatment through insurance physicians") were representative of the requests formulated on these occasions.

Ethnography is especially good at probing into areas where measurement is not easy, where the issues are sensitive and multifaceted, and where it is important to get at the tacit, not the already evident.

(Dixon-Woods 2003: 326)

Acknowledgments

In the last four years I experienced the luxury of passionately following a research idea from the moment of its inception until the typing of the last word. Even though I felt driven to analyse discussions of medical quality, the realisation of this PhD thesis was by no means a linear path but rather one with many ups and downs, emotionally speaking but also in terms of ethnographic procedure. Apart from the appropriation of scientific skills and the thorough examination of a specific field, a PhD thesis probably teaches anyone how to manage minor and major crises effectively. In this respect, many people contributed to the realisation of this thesis, and I feel most grateful to all of them.

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Three (family) physicians, all members of the same quality circle, approached me with the topic of this thesis: Without the long-lasting and continuing inspiration and support of Drs. *Bruno Kissling*, *Sylviane Neuenschwander*, *Helen Hartmann*

and their colleagues in the *medical quality circle Elfenau*, this project would not have begun, and also would not have surmounted economic barriers in the early months. Additional thanks go to all the anonymous physicians whom I met, interviewed, accompanied, and observed throughout my research. They provided me with an intimate insight into their professional daily life, constraints and joys.

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Pictures

All pictures were taken by the author.

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Glossary

CME	Continuous medical education
DRG	Diagnosis-related group
EBM	Evidence-based medicine
EQUAM	External quality assurance in medicine, an independent foundation responsible for quality control and certification thereof in medicine
EQuiP	European association for quality in general practice/family medicine
FOPH (BAG)	Federal office of public health (*German* Bundesamt für Gesundheit)
FMH	Swiss medical association (*Latin* Foederatio medicorum helveticorum)
HMO	Health maintenance organisations
KVG	Swiss health insurance law (*German* Krankenversicherungsgesetz)
NBM	Narrative-based medicine
NHS	National Health Service
RCT	Randomised controlled trial
Santésuisse	Swiss association of health insurance companies
Tarmed	Tarif médicale
TQM	Total quality management
Wonca	World organization of family doctors

> Spreading neoliberalism entails convincing others that everyone should enact corporate form of agency […]. Other forms of agency are getting pushed aside. (Gershon 2011: 539)

1 Introduction

Until the revision of the Swiss health insurance law (KVG[1]) in 1996, external quality requirements were not a public issue in Swiss family medicine. In 1996, however, intra-professional ethics codes along with personal medical commitment no longer sufficed. They were now to be complemented by external quality control[2], evaluation, and measurement. Justified by the need for a reduction of costs in the health-care sector, quality was defined as a legal regulation (KVG art. 56 and 58). Health providers and health insurance companies were obliged to co-create and implement quality programs within a given time frame. Despite certain attempts to co-create some form of overall system of quality control, so far no such system has been realised. That is why up to now no mandatory system of performance assessment[3] exists. This legal requirement initiated the discourse on quality which I am analysing from the perspective of family medicine.

[1] Download legal text at http://www.bag.admin.ch/themen/krankenversicherung/index.html [05.06.2012].

[2] In the discourses about quality, actors do not stick to consistent usage of terms but apply notions such as quality control, audit, quality assessment, quality measurement, quality assurance, quality improvement and evaluation quite interchangeably. Against this blurred background I will try to be consistent in applying quality-related terms, choosing to use "quality assurance" (*German* Qualitätssicherung), "quality measurement" (*German* Qualitätsmessung) and "quality control" (*German* Qualitätskontrolle) because these are the terms most often used in the context of Swiss family medicine.

[3] Performance assessment is defined "as comparing or measuring deviations of observed clinical practice from recommended practice" (Contencin et al. 2006: 65).

In summer 2005 I was approached by a quality circle of family physicians who wished to carry out a research project on the correlation between "quality" and "complexity" in family medicine.[4] When we started the project, the family physicians were circling around the question of how clinical complexities that cannot be measured in numbers could be formulated and thus made visible. Their questions are well-mirrored in what Haridimos Tsoukas described in the context of evaluating the practices of surgeons:

> What is missing from this account, however, is an understanding of medical practice as a complex social practice that cannot be recorded in the same way the act of, say, a passenger validating his/her ticket can. A surgeon draws on a set of skills that are collectively sustained as well as applied; he/she takes part in a form of life that cannot be fully accounted for through an externalist perspective. A camera hears only what can be articulated, not what is tacit; it conveys only what can be seen, not what is taken for granted. (Tsoukas 1997: 135)

The search for methods by these family physicians – methods that would allow for this externalisation – brought them to anthropology. Not being scientifically familiar with medicine, physicians or quality matters, I was thrown in at the deep end of the pool. I could best describe my impressions after the first meeting with the family physicians as chaotic and fuzzy, as well as perceiving a strong mission and commitment on their side. As I learnt later, these feelings were initial indicators to me about the mechanisms of the quality discourse as such. *Chaos* and *fuzziness* in fact characterise the various, blurred and inflationary ways in which quality matters are articulated and negotiated both within and outside of family medicine. Similar to "health", which Georges Canguilhem (2004: 54) denied is a scientific term but rather is a colloquial one, the understanding and interpretation of quality depend on one's own position (DelVecchio Good 1995). In the interviews which I have carried out, family physicians have highlighted the manifold ways in which quality can be understood. Therefore, what quality means depends on the perspective from which the medical

[4] The terms family physician/doctor, family medicine, and family practice are used here as synonyms for general practitioner and general practice. In the Swiss context these terms include physicians who have undergone postgraduate training in general practice or internal medicine, and who work as family physicians in the ambulatory setting. Since 2011 family physicians' specialty training is called "General internal medicine" (*German* Allgemeine Innere Medizin).

setting enters into reflection. Accordingly, the aim of conducting research on this topic proved to be a complicated endeavour. As for the work already addressing these concerns, aside from lacking clarity and precision, there is almost no interest-free, independent social-scientific research on this matter. Currently, social science is partially involved in the development of the relevant measurement and control tools. It is thus social-scientific research which contributes to the further development of the modern quality rationale in health care, but not to research specifically devoted to the quality rationale itself. Therefore in the Swiss context no independent research has been carried out which studies the quality notion, in either general or medical terms. Furthermore, because of the largely unexplored nature of the medical quality rationale and its associated discourses, it was hard to limit research on the matter, with the result that at times I perceived the ever-ramifying connections and correlations as if they were an army of Babushka dolls. I felt relieved when the moderator of a conference on quality opened her introduction by stating that focussing on a single term like quality can truly drive you nuts.[5] I have felt this way myself more than once. The terms *mission* and *commitment* in my analysis point to the ways in which these family physicians showed engagement with the project, and reflect my own understanding of their attitudes as I came to know their daily work, professional status and future. During my research these aspects of their profession posed crucial challenges to my role as an independent researcher, prompting me to reflections on subjectivity, objectivity and the professional distance needed when conducting ethnographic research on one's home ground and on a highly political topic. At that time, of course, I was not aware that all these first impressions would later become important issues in my research.

The aim of this PhD thesis is both to analyse this imprecise and blurred landscape and to frame the idea of quality in family medicine empirically as well as historically. Framing, here, is not used in the structural-functionalist sense as elaborated by Gregory Bateson (1955) and further developed by Erving Goffman (1974), but rather in a social-constructivist one (Bal 2002). In this sense it refers to a methodological as

[5] Yeboaa Ofosu at the *Qhoch3* conference, 5/6 November 2010 in Bern.

well as analytical concern. On the one hand, "framing quality" illustrates my own attempt to draw a line around those aspects of the medical quality discourses and related social practices that resulted from carrying out my research. The phrase thus refers to my attempt to disentangle, structure and interpret quality discussions in and about family medicine. On the other hand, framing also refers to family physicians' and other interest groups' perspectives on quality discussions. These perspectives have evolved historically and are tied to specific epistemological reference systems, positions in the health-care system and related interests. Both concerns are expressed in Dennis Chong & James N. Druckman's definition of framing:

> The major premise of framing theory is that an issue can be viewed from a variety of perspectives and be construed as having implications for multiple values or considerations. Framing refers to the process by which people develop a particular conceptualization of an issue or reorient their thinking about an issue. (Chong & Druckman 2007: 104)

1.1 Quality as a "travelling concept"

It was on a rainy Sunday that we celebrated my husband's birthday together with friends and family. After a lot of cake and small talk someone asked me about the topic of my PhD. I started to explain the issue of medical quality (which no one was interested in) and referred to quality control as a recent and global phenomenon (which everyone was highly interested in). Almost all people present were confronted with the issue of quality control in their workplaces. They work as a book seller, a grammar-school teacher, a computer scientist in university services, in the human-resources sector of a federal media enterprise, and as a top administrator at a mental institution. Although their working realities are very different from one another, they all share the experience of being subjected to quality controls on a regular basis. (Fieldnotes, 27 February 2011)

These fieldnotes illustrate a phenomenon that authors have variously called the "audit society" (Power 1997), "audit explosion" (Power 1994), "the age of transparency" (Sharman 2009), or "audit cultures" (Strathern 2000b). Irrespective of the field where

quality control is discussed, the claim for transparency, that is the "externalisation of interna" (Stehr & Wallner 2010: 9), marks the starting point of discussions. Through practices of externalisation such as audits, various fields of work are to be turned inside-out and thus "made visible" (Strathern 2000a: 313). In this respect, the aim of quality control remains the same wherever applied, namely, the creation of transparency, the manifestation of standardised procedures and thus the promotion of improvement and enhancement of controllability and sanctionability. Therefore it can be called a "globalizing practice" (Sklair 2001: 288ff), circulating through fields such as medicine, academia and general education, wrapped up in concepts such as "quality circles", "benchmarking" and "best practice" (ibid.: 113-115). "Transparency" is thus "embedded in certain practices […] of accountability" (Strathern 2000a: 313).

The modern quality rationale started out on its great journey during and after World War II, in the American armaments industry and the Japanese auto industry (Sklair 2001: 143; Mouradian 2002; Graf & Janssens 2008; Kenney 2008). It was in this context of post-war national competition that the "quality revolution" began to travel (Mouradian 2002: 77ff). Donald A. Schön describes this era as follows:

> All [research institutions] were organized around the production of new scientific knowledge and were largely promoted on the basis of the proposition that the production of new scientific knowledge could be used to create wealth, achieve national goals, improve human life, and solve social problems. Nowhere was the rate of increase in research spending more dramatic, and nowhere were the results of that spending more visible, than in the field of medicine. (Schön 1993: 38)

Quality control developed into a global mission and a market, both with a strong universalistic claim, and moved broadly through space and time, through both industrial and non-industrial sectors, into politics, the professions and the various discourses, and therefore into markets and rhetorics alike. I thus consider quality as a "travelling

concept" (Bal 2002). As Mieke Bal (2009: 20) states, travelling concepts[6] "[…] travel – between disciplines, between individual scholars, between historical periods and between geographically dispersed academic communities. Between disciplines, their meaning, reach and operational value differ". Bal's reflections on travelling concepts are clearly related to scientific settings. Quality, on the other hand, has been moving about through academic and non-academic settings alike. So, in order to apply Bal's approach to my topic, I need to stretch her notion of the travelling concept to non-scientific settings. In this context, I am particularly interested in the journey itself: What happens when the modern quality rationale travels from industry to health care? How does it move about and what does it transport and transform? How is it appropriated, negotiated or resisted? In short: What is this kind of circulation all about?

In this study I therefore present past actors and discourses that have served as catalysts in establishing the modern quality rationale in health care, and particularly in family medicine. In doing so, I try to reveal the varying contexts and meanings that lie behind the current quality controversy, a differential process that Bal explains as follows:

> Concepts are […] never simple. Their various aspects can be unpacked; the ramifications, traditions, and histories conflated in their current usages can be separated out and evaluated piece by piece. Concepts are hardly ever used in exactly the same sense. Hence their usages can be debated and referred back to the different traditions and schools from which they emerged, thus allowing an assessment of the validity of their implications. (Bal 2002: 29)

The unravelling of the historical development of modern quality thinking enables us to see how and in what sense quality became such a powerful and ambivalent issue in family medicine. In an interview Michel Foucault noted that analysing the historical embedment of phenomena is a necessity for understanding the power mechanisms at work:

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[6] From Bal's (2002: 31) perspective, "[…] concepts organize a group of phenomena, define the relevant questions to be addressed to them, and determine the meanings that can be given to observations regarding the phenomena".

> What's effectively needed is a ramified, penetrative perception of the present, one that makes it possible to locate lines of weakness, strong points, positions where the instances of power have secured and implanted themselves by a system of organisation dating back over 150 years. (Foucault 2005: 81)[7]

1.2 Disruption and re-definition of professional space

A range of different historical transformations and discourses, starting in the 1940s, promoted the establishment of the industrial quality rationale in family medicine. Among them is the crisis of representation in medicine after World War II, the setting-up of national health systems with their emphasis on cost control and sound planning, the fragmentation of medicine into an increasing number of specialties, the formation of family medicine as a discipline in its own right, de-professionalisation discourses arising among American sociologists[8], developments in medical science and technology, as well as the rise of neoliberal management logics from the 1980s on. The emergence and academisation of new health-professional groups, and the shift in the patient-doctor relationship commonly subsumed under the notion of *patient empowerment*, are further examples of processes of change that finally resulted in the break-up of professional medical boundaries and forced physicians to rethink their professional identities. In the Anglo-Saxon countries in particular, the social sciences played an integral part in early discussions of medical quality. In the U.S. American context, social scientists served as catalysts for critical discussions of professional autonomy and claims for transparency (Gebert 1980: 128). In the British context, social-scientific methods such as participant observation were applied to research about medical quality, particularly in the various quality reports carried out from the late 1940s onwards (s. section 3.2.1). Interestingly, apparently no such in-

[7] The translation stems from http://www.generation-online.org/p/fpfoucault6.htm [18.04.2012].

[8] Schön (1993: 11) explains that in the 1980s professional groups were in the midst of a crisis of confidence and legitimacy which was mirrored in requests for their "external regulation" (ibid.: 5). Apart from a growing awareness of professional limits in solving contemporary problems (ibid.: 39), larger transformations of the system ("bureaucratization", "industrialization" (ibid.: 13)) transformed the status as well as the working realities of professional groups.

volvement took place in the German-speaking countries. In Switzerland, aside from the establishment of evaluation research in various fields (ibid.: 130), the social sciences were not involved in the requests for quality control in medicine. Until 1996 medical quality control was the domain of the medical associations, only afterwards being shared between policy makers, health insurance companies and the medical associations.

Marco Stier (2009: 252) notes that medicine is increasingly determined by neo-paternalistic mechanisms, namely external regulation, economisation and objectification. In this respect, the Swiss federal claim for quality control is a concrete expression of how these mechanisms are put into practice. As a consequence of these processes of change, physicians were increasingly deprived of their exclusive status, being subjected to the commonly expressed notion of "deprofessionalisation" (Unschuld 2009: 68, author's translation). Whilst Talcott Parsons (1970: 33, author's translation) considered "functional specificity" as one characteristic of a profession, these processes dissolved the tight relationship between the functional system (medicine) and the profession (physicians) responsible for it (Stichweh 1997): Today physicians are no longer the only ones involved in medical services, but are complemented by other actors, groups and functional systems. The "increasing number of new expert occupations" (Kälble 2005: 9) reduced the knowledge gap that once defined physicians, and as a consequence has reduced the status gap between physicians and other health care professionals. That is why Thomas Kurtz (2002: 60, author's translation) notes that profession as a "form" is a "transitory phenomenon" that is already past its prime.

All of which is by way of saying that professional autonomy is no longer an untouched domain, but "has fallen increasingly under criticism […] in the last few years: Society's confidence in professions' self-monitoring […] is dwindling" (Kälble 2005: 6). Faith and trust are now replaced by the claim for transparency which can be described as a new technology of power and regulation. In her article Marilyn Strathern formulated poignantly how transparency is not only replacing trust but has also, in fact, become an expression of mistrust:

> As the term accountability implies, people want to know how to trust one another, to make their trust visible, while (knowing that) the very desire to do so points to the absence of trust. (Strathern 2000a: 310)

The information produced through audits and assessments symbolises a decrease and undermining of trust (ibid. 2000a: 313; Stehr & Wallner 2010: 11) in medical expertise. In this search for new certainties, trust is supplanted by a large amount of information (Stehr & Wallner 2010: 11). Consequently, the "language of accountability takes over the language of trust" (Strathern 2000a: 314). Interestingly, however, authors note that the produced transparency, instead of having a calming effect, intensifies the general perception of a need for even more transparency (Stehr & Wallner 2010: 13).

The call for transparency and the establishment of quality control have led to a far-reaching transformation of professional boundaries and competences, and therefore of the concept of profession as such. The following features[9] formally considered as constituting a profession have been challenged by the transformations in the health-care systems during the last two or three decades:

- Professionals are organised in a professional association.
- The professional association defines a specific "code of ethics" that professionals must follow.
- Professions have a specific knowledge base whose teaching is organised and conducted by the professional association.[10]

[9] This list is based on Kurtz's (2002) attempt to carve out the least common denominator of the different positions of the theory of professions. There exists a broad array of social scientific, mainly sociological work on professions in general, and the medical profession in particular. The early sociology of the professions was represented by scholars such as Thomas H. Marshall and Talcott Parsons (ibid.: 22) and later further developed by Anselm Strauss, Eliot Freidson, Andrew Abbott, Paul Atkinson, Ulrich Oevermann, Rudolf Stichweh, and many others. Other authors (Kurtz 2002; Rychner 2003; Kälble 2005) have published very helpful overviews on the different approaches that reach from structural functionalism, symbolic interactionism, to the theory of power perspective, structural theoretical approach, and systems theory. That is why I do not intend to go deeper into the different approaches and their theoretical premises but instead use Kurtz's condensation of the different approaches as a point of departure here.

[10] The specific type and complexity of knowledge is generally accepted as a central professional capital, combined with a specific professional habitus (Rychner 2003: 32; Pfadenhauer & Scheffer 2009).

- Professional work is considered a rather altruistic service for the general public, and targets central values such as education, justice, health, well-being etc.
- The relationship between professionals and their clients is asymmetric because the former are considered experts. This asymmetry legitimates professionals' autonomy in decision-making and conduct.
- Professionals have a monopoly of agency that is clearly separable from the work of other groups.[11]
- Professions are usually not allowed to advertise for their services.

In his article *Between professional autonomy and economic orientation – The medical profession in a changing health-care system* the medical sociologist Karl Kälble (2005: 5) for example emphasises that professional autonomy is challenged through economising processes in the health-care system (s. chapter 5). In the past physicians enjoyed freedom of choice in the fields of diagnosis and treatment, including physicians' exclusive right to decide between "necessary and appropriate" treatment, meaning for "how long and under which financial conditions" patients are treated (ibid.: 6). This implied that physicians' performance is independent of external control and surveillance (ibid.). By referring to the medical sociologist Johannes Siegrist, Kälble (ibid.: 6) states that from this perspective "the medical profession is able to determine the content, quality and quantity of work it performs on its own". Thus, with external claims for transparency and quality control, autonomous professional space gets severely disrupted. This impact illustrates the transformability of a profession and its status (ibid.: 4f).

External quality requirements challenge the professional self-concept, which builds on a control monopoly of medical knowledge, its production and application, as well as the definition of good care (Hitzler & Pfadenhauer 1999: 98). Authors have noted that physicians have managed to remain experts in medical knowledge and thus to avoid ceding control over it to external actors (ibid.; Stichweh 1992: 40). Yet the modern quality rationale illustrates that the overall professional monopoly has dis-

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Unschuld (2009: 6), for example, emphasises that the members of a profession not only create the knowledge themselves, but they also decide independently on how to apply it.

[11] Unschuld (2009: 6), for instance, notes that professional autonomy also includes the fact that professionals, here physicians, themselves decide how much they earn for their services.

solved, and that physicians now have to negotiate with external actors about how to define health, illness and patienthood, and how clinically relevant knowledge is produced and applied. This implies that decisions in medical practice do not follow clinical considerations alone but also must take into consideration economic, insurance-related or legal aspects (SAMW & FMH 2004: 10). In this context, physicians have mutated from being "designers to co-designers, from those responsible to those sharing responsibility", as Kälble (2005: 9, following Unschuld 2001), emphasises. As a consequence, family medicine has been forced to participate in quality discussions with other medical as well as non-medical actors about the definition, measurement, and control of medical quality. Ultimately, these discussions have not only negotiated what quality is or is not, but also the relationships between the different actors. Therefore, discussions of medical quality exemplify the tension and positioning that take place within this heterogeneous setting. In and through these extramural discussions, the different actors create images of both themselves and the others. One of my interviewed physicians noted:

> I believe that intersections exist [in relation to the different quality definitions]. But there's such a huge mistrust, a strong grudge [between the different actors]. Because everyone is creating a concept of the enemy. The health insurance companies create the doctor who only thinks about earning a lot of money. Physicians create health insurance companies who want to hold us on a tight leash. Patients believe that they are at anyone's mercy, that the health insurance companies want their money and physicians hold back their diagnosis. There exist many […] undifferentiated concepts of the enemy which are at the moment promoted instead of reduced. (Dr Christen)[12]

Along with this constant positioning goes an ongoing negotiation about the definition of family medicine. Although "traditional" aspects such as long-term patient-doctor relationships or contextual knowledge are acknowledged as professional principles, they are now framed differently. The role of family medicine is increasingly emphasised as a cog in the wheel of the larger health-care system, rather than constituting a profession in its own right. In this context, the terms "gatekeeper" and "triager" illus-

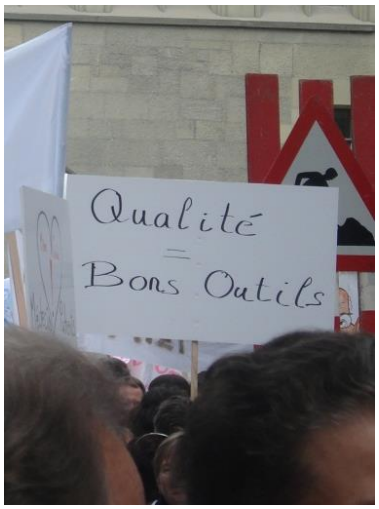
[12] S. table 2 section 2.2 for detailed information about the interviewed doctors. All interview quotations have been translated by the author.

trate that family physicians are seen as „double agents, expected to act as patient advocates, while also being financially accountable" (Rylko-Bauer & Farmer 2002: 485). Against this background, quality discourses are to a great extent discourses about professionalism.

Taking all of these factors into account, I consider the caesura of 1996 as a "discursive event" (Foucault 1974: 16, author's translation; Link 1997; Bublitz 2001; Schwab-Trapp 2001): It transformed medical quality matters from an intra-professional domain to a field of multiple expertise and negotiation. It represents the culmination of a decisive change in status for the medical profession, because with it professional autonomy is replaced by the shared control and administration of medicine by other actors and functional systems. This caesura forced family medicine to participate in quality discussions with other medical as well as non-medical actors. So 1996 initiated an ongoing re-mapping of family medicine that blurred the boundaries between intra- and extra-professional categories, and between State regulation and professional autonomy. It led inevitably to the re-framing of professional space and to the re-modelling of the "good physician".

1.3 Swiss family physicians going public

The above-mentioned disruptions transformed family medicine into a political space in which family physicians increasingly presented their interests, concerns, and political agendas to a public audience, sometimes engaging in the direct performance of protest. In this respect, the quality notion and its linked concepts served as a rhetorical device and argumentation strategy for the framing of negotiations, legitimisations and realisations of proper interests and visions. The demonstrating family physicians presented slogans such as "Family medicine: proximity, quality and continuity", "Quality = good instruments" and "Family-medicine quality instead of mass treatment through insurance physicians".



Pictures 1-3: Day of family medicine 2009 and 2011, transparencies with quality slogans

As I am going to show with the example of family medicine, negotiations are about medical knowledge and its production, definitions of health and illness, professional expertise and autonomy, and tradition, identity and future scenarios of the discipline. This manifold concern means that quality discussions are not only about improving medical performance, but also about negotiating professional boundaries and positions (DelVecchio Good 1995). In this respect 1996 marked a change in the various intra-professional quality activities, positions and rhetorics, inasmuch as they now not only negotiated questions of clinical performance but additionally acted as instruments of positioning family medicine in the emerging quality dispositive.

So professional discourse not only became increasingly influenced by political discourses but also adopted an active political role as well, through politically motivated professional amalgamations[13], advertisement[14] or public demonstrations.

[13] Amalgamation of internists, general practitioners, and paediatricians to *Family Doctors Switzerland* (*German* Hausärzte Schweiz) in 2009.

[14] For instance, the association of family physicians in Zurich *Verein Hausärzte Stadt Zürich* mounted an advertisement campaign which included posters in public trams, radio spots and the publication of a trashy novel called *Family physician Doctor Bolliger* (*German* Hausarzt Dr. Bolliger, s. fig. 1). For further information s. http://www.hausarzt.ch/content/infos.php [23.04.2012].

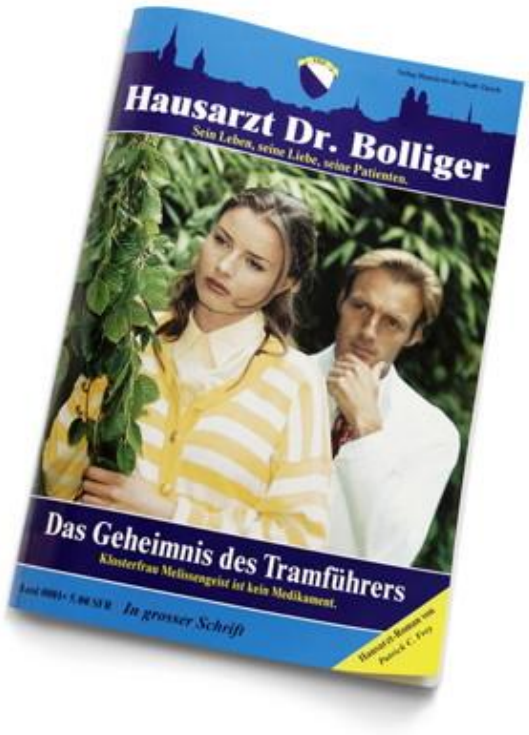


Figure 1: Trashy novel *Family physician Doctor Bolliger*

On 1 April 2006 the first national demonstration of family physicians took place in front of the Federal Palace in Bern with an estimated 10'000 participants (family physicians, medical practice assistants, patients and supporters). In the years following, 1 April was named the *Day of family medicine*[15]. One interviewed doctor, while he characterised this political role as a novelty, doubts that it will have a significant influence on the profession's future:

> […] physicians are apolitical. […] I [always] advocated opening one's trap and speaking one's mind, and that one gets up on his hind legs right from the get-go. This wasn't approved at all in the past. The Swiss physician is silent, a silent sufferer. He makes sacrifices. He is just a nice guy and does everything the way he's supposed to. And now we're in a crisis. We've created exactly what I've… I've already told them 30 years ago […]: "One day you'll be nobody!" And that's where we are now. We think that we have a say but we don't have much of a say. I also don't believe that the 1st of April two years ago [2006] changed much of anything. (Dr Lehner)

[15] *German* Tag der Hausarztmedizin.

Nevertheless, the driving actors behind the demonstrations by proponents of family medicine tried hard to create a historical event whose capital they could keep drawing on. They orchestrated performances which took place in carefully selected, highly visible spaces, and which dealt with specific issues such as the scarcity of future family physicians, cuts in the laboratory tariff and physicians' salaries, or the need for a university institute of family medicine.

The 2008 demonstration bore the theme, *The time is ripe for the Institute of Family Medicine at the University of Bern*,[16] based in a tent erected pointedly (and without official permission) in front of the *University of Bern*'s main building. In 2009 a protest march was organised that started at Bern's town hall an ended with speeches in front of the office of the Swiss Federal Council in charge of the *Federal Office of Public Health*[17]. It was followed by the inaugural ceremony of the *Institute of Family Medicine* at the *University of Bern*. In 2010 the demonstration again took place in front of the Federal Palace,[18] this time organised around the submission of the popular initiative[19] called *Vote yes for Family medicine*[20]. The collected signatures were transported to the Palace by an ambulance so as to underline the urgency of the matter.

[16] *German* Die Zeit ist reif für das Institut für Hausarztmedizin an der Universität Bern.
[17] This was at the time Pascal Couchepin.
[18] *German* Bundeshaus.
[19] In the glossary of the *Federal Authorities of the Swiss Confederation* this is defined as a "[r]equest submitted by a minimum of 100,000 voters to undertake a complete revision of the Federal Constitution or to adopt, repeal or amend a provision of the Constitution" (http://www.admin.ch/glossar/index.html?lang=en&action=id&id=57 [19.04.2012]).
[20] *German* Ja zur Hausarztmedizin. This initiative dealt mainly with the threatening scarcity of future family physicians, and requested a long-term policy to promote family medicine (for more information s. information material and press release on http://www.jzh.ch/ [19.04.2012]).

Picture 4: Day of family medicine 2010, ambulance carrying signatures to the Federal Palace

1 April 2011 was again celebrated in front of the Federal Palace, the main issue being the opening of a national bus tour aimed at sensitising people to the concerns of family medicine and winning over their voices for the pending vote on the submitted initiative. Inside the bus the proponents illustrated their concerns through key messages such as “To see integrally”, “From head to toe”, “All life long” and “From person to person”.

Picture 5: Day of family medicine 2011, unveiling of the family medicine bus

These demonstrations were orchestrated through biomedical symbols (all physicians wore a white coat[21], some also a stethoscope), advocacy banner texts, speeches in front of parliament buildings, and the invitation of physicians' families and patients to represent family medicine's closeness to the people. All this was documented and published by press representatives.

Pictures 6-7: Day of family medicine 2009 and 2010, inclusion of family members and supporters

The messages on the demonstration banners were marked by a morbid rhetoric which aimed at emphasising the profession's "dark" future.[22] A doctor (Dr Frei) recalls that the local professional association suggested banner texts that would draw on state-

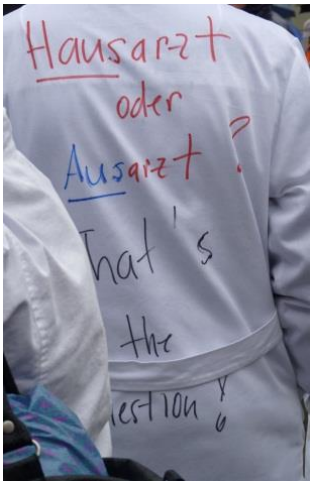
[21] This dress code is an interesting example of how family physicians refer to biomedical symbols in order to legitimise their concerns. During my research most of the family physicians were dressed casually, wearing a white coat only in specific consultations where they aimed at staging their professional authority.

[22] Already in the late 1960s "funeral eulogies" were held about general practice (Rehli 1985: 1717), yet not in public spaces but in medical journals only.

ments such as "Family doc†or"[23] to illustrate the desperate state of family medicine. Others presented statements such as "In memoriam – we're mourning the family physicians", "Family physician: in danger of extinction", "Am I the last family physician?", "First dies the practice, then the patient", or "Only whales die more silently than family medicine practices" (author's translations, for pictures s. next page).

In the demonstrations but also in the interviews, family physicians stressed the necessity of fighting against this threat of death and maintaining control over family medicine. One interview partner emphasised that "medicine must remain in the hands of physicians" (Dr Lehner). Confronted with these recurrent references to the dying profession, I increasingly asked myself what kind of family medicine and what type of family physician this grieving is all about. The performances were attempts to stage a professional corporate identity that represents family medicine's univocal interests. For this purpose family medicine was to a certain degree mythologised and essentialised – a transformation which not all family physicians appreciated. Accordingly, during the data collection I encountered a heterogeneous array of opinion and feeling, which supplemented the relatively homogenous stance proclaimed at the demonstrations. This heterogeneity included not only different local working settings but also preferences of different practice models (s. section 5.3).

[23] *German* Hausarz†.



Pictures 8-13: Day of family medicine 2009 and 2011, morbid rhetoric used to stress the dark future of family medicine

1.4 Aims and research questions

In an attended summer-school workshop on quality improvement in primary care, it was stated that it is unethical *not* to measure quality, and that one is *obliged* to measure quality.[24] This shows the typical discursive move, that questions about medical quality are raised in a normative frame. Avedis Donabedian (2005 (1966): 692) laid emphasis on the fact that quality "may be almost anything anyone wishes it to be, although it is, ordinarily, a reflection of values and goals current in the medical care system and in the larger society of which it is part". In this respect quality definitions set up a normative frame for products, services and performance (ibid. 1980: 13). This norm defines the range between what is considered as "good" and "bad practice", in particular what is right or wrong practice.[25] The difficulty in defining quality as doing things properly or "right" and in standardising "best practice" is expressed in an interview passage with a family physician. First, he emphasises the importance of treating his patients in the "right" manner:

> To me it's of primary importance to do my professional homework. So that I can say that I've treated a problem correctly. So that I can stand in front of every specialist and say that I've prescribed the right antibiotics, that I've defined the right moment of referral, that I've arranged a hospitalisation at the right moment. That's important. (Dr Gebhard)

So, a good doctor is apparently somebody who is able to make the right choices, to determine adequacies: the right medication, the right time for referrals and hospitalisations. In this respect, quality seems to correlate with a dualistic perception of right and wrong which supports the normativity attached to quality that I mentioned above. Yet, as the interview proceeds the same doctor deconstructs and relativises this dualism by explaining that doing things right often does not happen in a schematic, structured way, because things are not always so clear. The social, economic and emotional conditions patients live in, and the working environment and regula-

[24] Jochen Gensichen, family physician and professor of general practice at the *University of Jena* (Germany) in the *EQuiP Summer School 2011: Research and developments in quality improvement in primary care* which took place at the *University of Ghent* (Belgium), 28.-31.08.2011.
[25] In his work, Donabedian uses the terms "quality", "goodness" and "perfection" interchangeably.

tion of the physicians, are to a large extent determining factors for the adequacy of procedures. The doctor reflects further:

> At times I might overrun the time [of a consultation]. Yet, I've listened to somebody, which might have been important. Because of that, someone else needed to wait for a while, perhaps. This is exactly what quality norms judge. Sometimes I examine things differently than I'm supposed to. I decide to omit something in this case because it does not make sense to me. Be it because of the whole polymorbidity or the age [of a patient]. I then omit it on purpose. In that way I can stand behind it [treatment]. (Dr Gebhard)

These brief quotations illustrate the field of tension inherent in medical quality discussions and individual physicians' attempts to position themselves in that same field. They also show that quality apparently is not something ready-made but rather is something constructed in a particular context. The interviewed physicians all stressed that quality is a multi-dimensional concept, and that "different kinds of quality" (Dr Tanner) exist. In my research diary I noted:

When I asked my interview partners about their perceptions of quality, their answers could hardly ever be divided into single aspects. It was mainly through stories, through case-narratives, that physicians could explain best what they understood as good quality, that is, where the constraints for good quality lay. During my visits to settings where medical quality issues are discussed (conferences, summerschools, workshops) I was often asked how family physicians define quality. Although this is one of my crucial questions, I usually felt incapable of answering it in the short time slots available on these occasions. I hear myself answering in ways such as "They have a very broad understanding of it" and "It is very complex and multilayered". Although this might well be an expression of social anthropology's incapacity for clear-cut and short summaries (as a famous epidemiologist once complained in a seminar), or it could also be an expression of the topic as such: The ways in which family physicians understand quality cannot be separated from the ways in which they understand the principles of family medicine. Beside socialisation as family physicians, the local environments play a crucial role in the ways medical quality is perceived. (Fieldnotes, 16 April 2011)

This being said, the aim of my research is thus *not* to measure or determine medical quality or to develop quality indicators, *but rather* to analyse how it is talked about, negotiated and interpreted by family physicians. In other words, my understanding of quality is a social-constructivist one that aims at understanding what the quality notion is used for, when, how, and by whom it is constructed and applied, and what meanings and social practices are attached to it. Therefore in my research I do not use quality as an analytical concept but as an object of research. In this respect I stick to the perspective of family physicians and their professional associations. Despite the inflationary and regulatory use of the quality notion, astonishingly little is known about family physicians' perception of quality. In this context, Donabedian's citation from over half a century ago still remains true:

> Little is known, for example, about how physicians define quality, nor is the relationship known between the physician's practice and his own definition of quality. (Donabedian 2005 (1966): 717)

Throughout my analysis I will oscillate between this level of individual experience and agency and the level of political structures and discourse, an approach increasingly followed in medical anthropology (Jenkins et al. 2005: 15; Samuelsen & Steffen 2004: 3). This oscillation will be framed theoretically with Foucault's concepts *discourse* and *dispositive*.

Against this background I conceptualise quality discussions as a *quality dispositive* through which different discourses are running, all of which negotiate the question of what quality is, and by whom and in which manner it should be controlled. During the analysis of this dispositive, I found that Foucault's notions of *power* and *subjectification* proved to be most helpful in leaving behind a simplified perception in which quality control is seen as a regulatory instrument forced onto family physicians by policy makers. Rather, as I have indicated earlier, it was also strongly established and promoted by representatives of family medicine and recently was applied by them in staging their discipline in public. It thus also serves as an instrument for positioning (Davies & Harré 1990). In their article *The relevance of Foucault and Bourdieu for medical anthropology: exploring new sites* Samuelsen & Steffen summarise:

> The concept of power seems unavoidable in studies of health and illness, not only in the most obvious forms of institutional power or authoritative power as demonstrated in health care institutions, but also the configuration of power in specific social settings in the more subtle form of self-discipline as pointed out by Foucault. His study of power is not formed as an attack on the exercise of power by specific institutions, groups or elites, but rather as a study of the techniques, or the forms of power as enacted in relations between individual agents and incorporated in each individual. (Samuelsen & Steffen 2004: 7)

It is in this sense that I intend to analyse the quality dispositive. Based on my data collection I have identified four key discourses that run through the quality dispositive: these are negotiating *cost-efficiency*, *evidence*, *patient-centeredness* and *patient safety*.

1.5 Structure

In *chapter2*, I present my methodological choices and procedures and reflect on the challenge in moving from contract research to independent research. In *chapter3*, I sketch the journey of the modern quality idea, applying Bal's (2002) notion of the "travelling concept". I show how industrial ideas of improvement were transferred to family medicine, and that this movement was strongly promoted by representatives of family medicine. The circulation of the modern quality rationale, be it globally or in Swiss family medicine, thus depends on specific actors as transmitters and multiplicators. *Chapter 4* maps the theoretical frame and concepts that guide my analysis and interpretation. Starting from the notion *quality dispositive*, I introduce analytical concepts such as *discourse*, *regulation*, and *techniques of the self*. The discourses running through this quality dispositive are, of course, intertwined. Nevertheless, they are discussed separately in the following three chapters: *Chapter 5* presents the analysis of the cost-efficiency discourse running through the quality dispositive and illustrates the effects of the *economisation of medicine* for daily practice but also for the definition of medical quality. *Chapter 6* addresses the issue of knowledge in medical practice which oscillates between scientifically produced evidence and the treatment of a specific patient. It thus focuses on the epistemological discourse nego-

tiated in the dispositive. *Chapter 7* analyses the quality concept of patient safety, shedding light into the era of medical fallibility and the attempts to control it.

Doctor Aeschbacher | Passionate about psychosomatic medicine[26]

Dr Aeschbacher is 56 years old and just separated from her second husband, an endocrinologist, with whom she had a double practice in a large city. She now works 60% in her family practice and 40% in a private hospital in the field of psychosomatics. She has two adult daughters from her first marriage. She established her practice ten years ago. Her husband joined the practice five years later and left after their separation. She regrets that they were not only a couple but also decided to work in the same practice. However, she now has to find another practice partner to be able to pay for the monthly expenses. She has outsourced services such as laboratory and x-ray due of their low profitability. Dr Aeschbacher has a heterogeneous clientele, reaching from adolescents to elderly or psychosomatic patients. Many of her patients prefer visiting a family doctor even though they suffer from mental health problems. For her, somatic and psychosomatic medicine is inseparable, and most of her colleagues work according to this approach. Her aim is to build a relationship with the patient yet without losing her professional distance. Dr Aeschbacher is member of a quality circle and a Balint group. She feels critical about the influence of the pharmaceutical industry on medical work and about the development of a two-tier medicine where patients with low resources are increasingly discriminated and undertreated, whereas patients with high resources are increasingly over-treated.

At the beginning of her career, Dr Aeschbacher did not want to become a family doctor. She was afraid to get too involved into her patients' lives. This changed completely and she now feels very passionate about her closeness to her patients' living contexts.

Dr Aeschbacher complains about the time pressure of her work, the high amount of patients that come to see her, and her long working hours which influence her private life negatively.

She stresses, that she had to develop managerial skills in order to cope with the reorganisation and economisation of the health care system.

[26] The portraits of the interviewed family doctors are presented after every chapter. S. table 1 in section 2.2 for a complete overview.

Doctor Berner | Missing distance between doctor and patients

Dr Berner studied medicine as a second career. After his parents had separated his grades decreased. Therefore his father decided that Dr Berner would get trained in an administrative job instead of choosing an academic profession. After years of being bored he decided to study medicine and succeeded. After twelve years of working in the hospital he opened his own practice. Today Dr Berner works in a double practice together with his wife who is also a family doctor. They have a son who is 18 years old. Their practice is located in a suburban community and has a 1980s interior which can be encountered in many practices of family doctors close to retirement: slightly old-fashioned furniture and pictures but with a personal touch and clean, newspapers, journals and children books. Dr Berner lives and works in the same house. The two medical practice assistants are the interface of the whole practice and the first contact persons for patients either visiting or calling and often the ones who patients ask for further or more detailed explanation after leaving the consultation room.

Dr Berner has worked in his practice for the past eight years and is member of a regional Balint group. He has moved to the area from a different canton and still struggles with his lack of local knowledge. Especially when going for home visits he is often confused by missing road signs and house numbers and usually loses time until getting to the patient. Dr Berner and his wife both work as family doctors, yet with different fields of interest. Beside "normal" cases, Dr Berner is responsible for patients who suffer from mental problems. His main interest clearly lies in the field of psychosomatics. His wife is responsible for four homes for the elderly and performs gynaecological controls. Dr Berner does not perceive the double practice as a relief but rather as a double burden.

In general, Dr Berner and his wife have too many patients and they have to turn down some of the new requests. He used to treat patients from the surrounding communities. Due to his increased workload he and his wife now only treat patients from the village in which their practice is located. To live and work in the same village is ambivalent for Dr Berner: on the one hand he considers the closeness to the local community to be an advantage for his work. On the other hand, however, some of his patients do not distinguish between his opening hours and his private life. Dr Berner

perceived this demand for full time availability as a strong pressure and even thinks about moving away from the community. Additionally, the paperwork for referrals and insurance companies at the end of the day is constantly increasing. Dr Berner also struggles with the increasing hospital demands for perfection which he often perceives as overtreatment. He complains about his rare spare time and the impossibility to do sports which is why he has gained some weight. That is why Dr Berner thinks about reducing his volume of work but struggles with the idea of disappointing his patients.

Doctor Christen | Being a doctor and a mother

Dr Christen is in her sixties and works in a double practice together with her husband, also a family doctor. She works part time and is glad that this enables her to have a bit of spare time to reflect about her cases. Dr Christen is member of a quality circle, a Balint group and group of colleagues where intervision takes place or – if necessary – supervision with an external psychologist. Most of her colleagues in these groups practice medicine with a systemic approach, meaning that they adapt diagnosis and treatment to the patient's living and working context.

During her studies Dr Christen did locum work in many rural practices where she got used to the whole spectrum of family medicine. She also realised that she would never want to work in a single practice because of the isolation and the full time availability and responsibility. After her studies in general practice Dr Christen had a long professional time-out during which she gave birth to four children. Parallel to her time-out Dr Christen's husband established his own practice which she joined after approximately 15 years. Beside "regular" cases she also offers psychosomatic counselling and gynaecological controls. Most of her patients are rather young which is why she does not do a lot of home visits. Most of her patients visit an urban emergency unit when there is an urgent problem at night or at the weekend.

Even though Dr Christen will soon be retired she is still very passionate about working as a doctor. However, she lists several dimensions of her work which she considers to be difficult. Among them are for instance the increasing "Americanisation of medicine", i.e. the threat of sanctions in cases of misconduct. Further issues are the missing trust between the different health care actors, or increasing patients' de-

mands for full medical check-ups resulting from patients' uncertainty and high risk perception even though – or because – they have access to many health related information.

> The logic of someone's thought is the whole set of crises through which it passes; it's more like a volcanic chain than a stable system close to equilibrium. (Deleuze 1995: 84)

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2 Methods

2.1 From contract research to independent research

This research started out as contract research. As I have noted earlier, in summer 2005 a quality circle of family physicians mandated that I carry out a research project about "quality" and "complexity" in family medicine. The physicians felt uncomfortable with the quality notion which, from their perspective, increasingly neglected non-measurable, "complex" aspects of care; they wanted a research project that would focus on these tacit dimensions. One of their members was not only a physician but also a social anthropologist who therefore introduced ethnographic approaches to the quality circle. Through that connection, I got in touch with this group. I was paid to write a research proposal for a foundation which would, so it was hoped, support a larger research project. However, the route from submission to the first tranche of funding proved to be a rocky road. We submitted the proposal to the *Swiss Academy of Medical Sciences (SAMS)* twice, having to convince the medical board of this academy of the value of qualitative research methodology. In spring 2008 the research project officially began, and was later continued thanks to a research grant from the *Swiss National Science Foundation (SNSF)*. Retrospectively, one can see that the change from *SAMS* to *SNSF* funding was necessary to move from contract to independent research, i.e., from research for family medicine to research about its position in the quality dispositive. The quality circle of family physicians provided me with extraordinary access to their working environment and their

closed peer group. Through this channel I gained access not only to a large professional network but also to confidential, intra-professional discussions. However, at the same time this research topic was highly political. Back then I did not yet realise that family physicians are in need of scientific voices that would support their positioning in the rapidly-transforming Swiss health-care system. After I decided to enlarge the project into a PhD thesis, this collaboration turned into a tightrope walk between being very close to my informants and the necessity of keeping a critical analytical distance. This situation of stretch was enhanced by the fact that I could not make up my mind about how best to affiliate my research, whether to medicine or to social anthropology. An additional constraint was the fact that I could not find anyone conducting research into medical quality from an independent standpoint. Those people I read about or got in touch with were all involved, in one way or another, with further developments of quality control programs,[27] and thus practicing "embedded science" (McClelland & Fine 2008). Hence, the first two years of this research, apart from collecting data, were heavily dedicated to the search for my own scientific position.

2.2 Data collection

The aim of this project was to collect data from a maximum of settings and spaces where the quality of family medicine is reflected, discussed and negotiated. The data corpus thus consists of different types of data, including fieldnotes, interview transcripts, case narratives written by physicians and audio recordings and pictures from conferences and demonstrations. I have been part of a monthly quality circle of family physicians for seven years. Especially at the beginning of my research, this peer group represented my main access to the field. In their meetings I mainly acted as an observer, although also with permission to add comments or raise questions. In the first months some members felt uneasy about my presence but also got used to it, so that after a while I was officially admitted as a member of the quality circle and had

[27] For instance through quality indicators development, evaluations and certifications of practices, or the conduct of large scale quality improvement programs.

access to the group's exchanges until the very end of my research. I purposely[28] conducted formal interviews only with three of the group's members, but was able to benefit from their professional networks so as to get in touch with more interview partners. Before the first interview took place, I put down the following fieldnotes:

Having talked a lot about medical quality with the quality circle of family physicians in Bern, I was looking forward to meeting physicians who were not part of these local discussions. On the way to my first interview partner who lives in the mountains, I enjoyed moving further and further away from the city, and thus moving further and further away from the quality reflections I had become familiar with in the previous months. Here, in this changed environment, I sensed that doing research requires one to change focus regularly and to move in and out of settings that one has become familiar with. Almost all of the physicians I have worked with so far work in or right outside of the same city. That is why I was eager to meet a doctor in a remote area who works under different conditions than the ones in urban settings. (Fieldnotes, 6 July 2008)

As the research proceeded, gaps in my data collection appeared, and I sampled increasingly selectively by specifically approaching, for instance, physicians working in *HMO (Health maintenance organisation)* practices or a representative of the *Swiss Medical Association (FMH)*. Apart from many informal talks with family physicians and two expert interviews, I eventually interviewed 20 physicians (s. tab. 1) in various practice settings in the Canton of Bern, participated in some of their consultations, and collected case-narratives written by them and by non-interviewed family physicians. Additionally, I visited family-medicine conferences, training sessions and demonstrations, and took part in two international summerschools on quality improvement in primary care. Thus, my participant observation did not take place during a defined and uninterrupted time span but sporadically over a period of seven years. In this respect I struggled with the "boundaries" of the field (Nordquest 2008). First, in terms of "geographical" boundaries: I did not do research in a closed institu-

[28] Through my regular attendance of the quality circle meetings, I was prompted to see the importance getting beyond this group's horizon of discourse and talk to other doctors too.

tional setting, for example, but in various settings that were not directly linked with each other, pursuing questions about the circulation and negotiation of a concept. I felt divided between conducting research mainly in one site, such as a particular practice, or in a multitude of settings in which quality is an issue. Eventually I did the latter, although of course that kind of immersion differed from staying with a particular practice for a longer period of time. Second, in terms of "temporal" boundaries: Even though my data collection is complete, medical quality discussions are ongoing. The field is thus constantly being further transformed, whereas I had to terminate data collection at a given point.

Doctor	**Sex**	**FMH title**	**State examination**	**Practice form**	**Location**	**Portrait**
Aeschbacher[29]	f	Internal medicine	1985-1990[30]	Single-handed practice	City	End of chp. 1
Berner	m	Internal medicine	1985-1990	Double practice	Suburb > 5'000[31]	End of chp. 1
Christen	f	General practice	1970-1975	Double practice	City	End of chp. 1
Debrunner	m	General practice	1980-1985	HMO group practice	City	End of chp. 2
Escher	m	Internal medicine	1985-1990	Double practice	Suburb > 10'000	End of chp. 2
Frei	f	General practice	1975-1980	Single-handed practice	City	End of chp. 2
Gebhard	m	Internal medicine	1980-1985	Single-handed practice	Suburb > 5'000	End of chp. 3
Hauser	m	General practice	1975-1980	Double practice	Town > 1'000	End of chp. 3
Isler	f	General practice	1975-1980	Group practice	Town > 10'000	End of chp. 3

[29] The names of all interviewed doctors are pseudonyms.
[30] Exact year of state examination lies between 1985 and 1990.
[31] Number of citizens.

Jakob	m	General practice	1980-1985	Double practice	City	End of chp. 4
Kuhn	m	Internal medicine	1975-1980	Double practice	City	End of chp. 4
Lehner	m	General practice	1965-1970	Retired, formerly in single-handed practice and HMO group practice	City	End of chp. 4
Meier	f	General practice	1995-2000	HMO group practice	City	[32]
Notter	m	Internal medicine	2000-2005	Single-handed practice	Town > 5'000	End of chp. 5
Odermatt	m	General practice	1970-1975	Double practice	Town < 2'000	End of chp. 5
Peters	f	Internal medicine	1995-2000	HMO group practice	City	End of chp. 5
Quinn	f	Internal medicine	1990-1995	Group practice	Suburb > 10'000	End of chp. 6
Ruch	f	General practice	1990-1995	Single-handed practice	City	End of chp. 6
Sieber	m	General practice	1985-1990	Single-handed practice	Town < 1'000	End of chp. 6
Tanner	m	General practice	1990-1995	Single-handed practice	Town > 2'000	End of chp. 7

Table 1: Sample of interviewed family physicians

The interviews with family physicians were semi-structured (Bernard 1988; Silverman 2005), moving from rather general questions about their working reality and preferred working style to specific questions about their own definition of medical quality and their perception of public discussions on this issue. I continuously adapted the interview guideline as the research proceeded. During the process of data collection I noted:

[32] The interview with Dr Meier was very short and took place by e-mail. That is why there does not exist a portrait of her.

When I started my data collection in 2008, I felt a certain reluctance and scepticism among the family physicians that I asked for an interview about this topic. They were either fed up with the term "quality" or they did not understand exactly what I wanted to talk about. I decided to avoid the term quality whenever possible and instead used notions such as "good medicine", being a "good doctor" etc. This verbal shift from an abstract to a concrete level that had something to do with personal professional attitude and experience was very important. (Fieldnotes, 12 August 2008)

When I met the medical quality circle that I accompanied for seven years, the group was fascinated by writing case narratives about patients (Czarniawska 1998; Greenhalgh 1999; Greenhalgh & Hurwitz 2005a; Mattingly & Garro 2000). In these narratives the physicians paid attention to their tacit knowledge about patients, to aspects that they would not necessarily write down in the patient record, as well as to their own role in the relationship with the patient. I noted:

In contrast to conventional case reports, the case narratives contained a great deal of contextual information, but also mirrored the voice of the doctor: The narratives are thus not trying to describe circumstances objectively, but from the doctor's perspective. That is why his/her perception, emotions, and working conditions are part of the narratives. I remember my immediate fascination with these stories which the physicians used as a form of illustrating their accumulated, multilayered knowledge. In the quality circle meetings, the writing of case narratives stagnated after a while. However, the case narratives became an inherent aspect of the meetings (if they had not been so before anyway). In talking about a specific topic, there were always insertions such as "I once had a patient who…" or "one of my patients…". (Postfestum reflection, 8 November 2011)

The quality circle's case narratives caught my interest. Consequently, when I started out with my data collection, I intended to ask the participant physicians not only for an interview but also for a written case narrative. After the first couple of physicians wrote such narratives for me, I began to realise that this procedure unintentionally limited my access to potential participants. I assumed that only those who like to write, who feel apt in writing or who feel close to narrative approaches would partic-

ipate in my research. That is why I decided to leave the writing of a case narrative up to the participating doctor. With those who wrote a case narrative before the interview took place, I used this narrative as a starting point in the interview. With those who did not write a case narrative, I asked them to tell me about a patient who came to the practice that morning or afternoon. In both ways I could start the interview with a concrete example, which proved to be an adequate methodological choice. This helped to break the ice quickly with physicians, most of them unknown to me, for then the interview could shed its formal character to a certain extent. This allowed me to reach some depth quite fast, something that I appreciated due to the time pressure under which most of these physicians worked.

The case narratives I read or listened to were not smooth accounts but rather contained aspects of tension, contradiction, uncertainty, anger, frustration and the like. Therefore they were about extraordinary cases; they clearly motivated the physicians to write about them. This specific form of writing is illustrated in the example of the following case narrative:

> Friday morning, I enter the waiting room and call my patient Miss S., 28 years old, by her first name. I feel embarrassed and I correct myself quickly. In the past her mother, a Portuguese immigrant, worked as a room cleaner in my house. Miss S., still a child back then, used to accompany her during her school holidays. Both her parents worked until they dropped to enable their children to have a better life. Miss S. failed to finish her studies. Her parents moved back to Portugal two years ago.
>
> Miss S. follows me into the examination room. She seems restrained, her face is pale, expressionless, her voice lower than usual. She tells me that she spent her holidays in Portugal where she suffered from a bout of diarrhoea. She should have returned to work on Monday. Her voice trembles, her face is slightly reddened. She goes on telling me that in front of her office she was paralyzed with fear, unable to enter the building and all of a sudden aware that she would never again return to her working place. She hurried back home where she had severe abdominal cramps and diarrhoea again.
>
> Now she is crying. I feel her helplessness, sadness, but also defiance and anger. It turns out that before leaving for her holidays she had been dismissed. She admits that she could not cope with her job anymore, but still felt that her employer treated her unfairly. At this moment I remember how easily she quit her studies

> in order to start with this job, seduced by the prospect of earning quick money. Do I see her eyes flash with anger? Anyway, she talks in a more lively and vigorous manner now. She lets me know that in the meantime her boss has agreed that she does not have to return to work anymore. He only needs a medical certificate attesting her inability to work for the next three months until her cancellation period is over.
>
> This surprising turnaround irritates me: Is it really that simple?! Are my patient and her boss taking advantage of me? Trying to take a decision, I'm caught between contradictory roles. I feel:
>
> - like the *worried physician* who suspects late adolescence problems in a young woman with an immigrant background,
> - like the *anxious friend* of the family who does not want to give up on her so easily,
> - like the *mother* who simply wants the best for her daughter and who – at the same time – feels the necessity of setting limits,
> - like the *solidarity woman* who does not want to witness the discrimination of a young immigrant daughter who has no real education,
> - like the *physician under pressure* of time who would like to solve this case immediately and definitely.
>
> The patient was supposed to be a simple diarrhoea case, but more and more I found myself in a most complex story with different layers that will influence my decision making.[33]

This case narrative mirrors many of the characteristic features which Greenhalgh et al. (2005a: 444) listed. They consider narratives to be "perspectival", to "make sense of experience", to be "non-linear" and "embedded in a context", to "have an ethical dimension", to "bridge the gap between the formal codified space of an organisation (roles, job descriptions, and lines of accountability) and informal uncodified space", to "offer insights into what might have been", to be "action-oriented", and to be „inherently subversive since […] they embrace the tension between the canonical (i.e. an organisation's standard routines and procedures) and the unexpected (i.e. new ways of thinking and working)".

[33] This case narrative was written by a family physician whom I did not interview formally, and who therefore is not included in table 1.

2.3 Data analysis

During the conceptualisation phase of my research, I had precise ideas of how to avoid building up a heap of data that needs to be analysed all at once. In a first attempt to avoid this, I divided the data collection into three phases, between which I set aside period of time for analysis. Initially I planned to conduct, transcribe and analyse one interview after the other. But this plan proved to be unfeasible, chiefly because the time slots that physicians could allow for interviews were often very close to each other. Despite my good intentions, I remember the process of transcription, structuring and first-level categorisation of the data as being very time-consuming. After it was completed, I found myself in front of a thick pile of sorted data which I realised was only descriptive and not yet interpretative. Despite the fact that I had already been through that moment of paralysis in which one seemingly does not know how to turn "raw data into 'cooked data'" (LeCompte & Schensul 1999: 3), i.e., to get from description to interpretation, I found it hard once more.

In attempting to make sense of the data, or re-contextualise the descriptively decontextualised (Starks & Brown Trinidad 2007: 1375), I benefitted from the concept-based modules that were offered in the two graduate schools I attended.[34] These modules helped me to further develop my analytical sense but also to work with a set of "sensitizing concepts" (Bowen 2006) that supported my departure from the descriptive level of data analysis, toward a particular reflective stance. Among the most important concepts were *circulation*, *knowledge*, *performance*, *discourse* and *identity*. With these concepts I could step out of medical discourses and distinguish between family physicians' concepts (e.g., complexity) and my own analyses and arguments (e.g., defining complexity as a rhetorical figure for professional positioning). These sensitizing concepts let me work through the data, outlining links as well as contradictions and transformations and developing a structure on whose basis I could begin to write. The writing process, fortunately, I perceived as an additional,

[34] I was member of the *Swiss graduate program of anthropology* and linked to the *Institute of advanced study in the humanities and the social sciences (IASH)* at the *University of Bern*.

perhaps crucial part of the analysis, in which gaps, misinterpretations, and questionable conclusions became evident and could be revised.

I feel somewhat hesitant in giving a label to my methodological procedure. My oscillation between global quality discussions, the quality dispositive in the context of Swiss family medicine, and family physicians' positioning in this dispositive can certainly be captured with in the phrase, "discourse and dispositive analysis". In this oscillating process I kept looking for the discourses that were mirrored or reproduced in the interviews, and at the same time analysing how public discourse is appropriated, negotiated or resisted by family physicians. In this respect, discourses are not simply just "there" but are to be crystalised out of the data material (Bublitz 2001: 246) through the identification of elements such as discursive events, positionings, and hegemonic and counter-discourses (Schwab-Trapp 2001: 271). This process is structured into the initial step of descriptive analysis and a second step of interpretative analysis (Jäger 1994, 1999). However, I did not follow an "orthodox" analytic procedure, as can be found in some schools of discourse analysis, and I paid particular attention to individual voices and agencies, so as not to lose track of them in the rich entanglement of the constituent discourses.

Doctor Debrunner | From a single practice to a large HMO group practice

Since five years Dr Debrunner works in a large urban health insurance-run HMO practice together with five family doctors, medical practice assistants and with therapists. He holds a degree in general practice but also a degree in phytotherapy. Before working in an HMO practice Dr Debrunner had a single practice in a different part of the city and also worked at the medical faculty in the field of medical education. Most of his patients were residents. His HMO clientele is very different: many patients work in the city but live in the suburban communities. Many of his HMO patients did not choose him purposely as their family doctor but come to the HMO practice because they are insured in an HMO model. Many of them have a deprived socioeconomic background. His HMO practice has the means for regular (paid) quality circle meetings, intervision, supervision with an external moderator, upgrade training courses and a failure management system.

There was no obvious reason why Dr Debrunner took up his studies of medicine. However, during his years of study he got more and more interested in patients' stories. The more patient encounters he had, the more convinced he became to specialise in family medicine. Apart from the complexity of the cases which fascinated him, he soon realised that he could never cope with the high risk of failure in fields such as surgery. During his study years Dr Debrunner also worked as a moderator for scientific topics in different radio stations. Towards the end of his studies he and his family (wife and two children) travelled through Europe for almost two years and lived in a bus. After returning home he completed his studies. He did not work as a radio moderator anymore but started writing for medical journals. Today, Dr Debrunner regularly writes about cases or experiences from his medical practice. To him, these narratives are part of his personal reflection and mental hygiene.

Dr Debrunner stresses that even though family doctors enter relationships with their patients these relationships are institutionalised and can never replace private friendships. That is why he is convinced that only a balance between medical practice and personal life can prevent doctors from getting tired, frustrated, cynical, lonely or ill. For many years Dr Debrunner and his wife shared their responsibilities and both

worked part-time. Additionally, he laid emphasis on following creative activities such as playing music or painting.

Doctor Escher | Being close to life and death

Dr Escher is 56 years old. He and his second wife have established their own practice nine years ago. He has two children with her and two with his former wife.

His decision to become a doctor was influenced by his older brother who also studied medicine. Dr Escher studied biology for four years and then medicine for another six years. He developed an interest in dealing with people in difficult situations and issues concerning life and death. During his years of study and further education he worked in the fields of orthopaedics, surgery, internal medicine, obstetrics, haematology, and psychosomatics. Dr Escher left the hospital setting because he did not get along with the hospital structures (time pressure, competition, bullying) and because he was clearly interested in the broad approach in family medicine and the broad and almost criminalistic procedures to find out what a patient suffers from.

Dr Escher and his wife work in a suburban community and live just around the corner from where their practice is located. 10 to 20% of Dr Escher and his wife's adult patients suffer from psychosomatic illnesses. Another 10 to 20% percent of the patients are children. His wife also offers counselling in obstetrics. Dr Escher is an active member of a quality circle and a Balint group.

He considers himself not as an authority but as a counsellor and coach who supports the patient in developing coping and healing strategies. A „new generation of patients" but also the reorganisation of the health care system influence his style of working. Issues that currently bother him are the increasing demands of patients, the threat of prosecution in case of misconduct, the increasing orientation towards medical guidelines and their fragmentation of the human suffering, the vast array of different health insurance models, the federalistic structure of the Swiss health care system, the tight intertwinement of medicine and politics, and the increasing pressure to assess one's own performance.

Doctor Frei | When patients do not stop complaining

Dr Frei's practice is located in a quiet part of a city. The interior looks rather like an apartment than a practice: warm lights, many plants, colourful pillows and cosy corners. She works alone but rents out one room to a Shiatsu therapist. Dr Frei is 55 years old, single and has no children.

Apart from general medicine Dr Frei has also degrees in psychosomatic and psychosocial medicine, in breath therapy and worked over a decade part time in a centre for war and torture victims where she was confronted with post-traumatic stress disorders, depression, and further problems related to migration. After quitting there she started to work in the field of geriatrics and for a while also in the field of Alzheimer research. Currently she has many patients in homes for the elderly and also participates in a quality circle with members from this medical field. Apart from elderly patients her clientele is rather mixed.

Even though Dr Frei has specialised in psychosomatic and psychosocial medicine, over the years she has increasingly lost patience and empathy with those patients suffering from chronic pain who demand quick treatments, who define care as a self-service shop, who see one doctor after the other, or who do not cooperate. To control and avoid her aggressions she writes down cases that bother her, participates in a Balint group, and works with a supervisor.

Dr Frei is very critical about politicians or non-practicing experts who discuss and decide about family medicine and thus challenge her professional ethos.

Even though she still likes the core issues of family medicine such as serving as the first point of encounter for many patients, Dr Frei is looking forward to her retirement because she struggles with the reorganisation of family medicine which is mirrored in electronic patients records, lower salaries, decreasing professional status, increase of further education requirements, conflicts with insurances, the load of daily information, or new payment structures such as Tarmed.

> Everything is being scrutinized with the mission of performing BETTER, FASTER, CHEAPER AND SAFER than any global competitor. (Citation of a CEO quoted in Sklair (2001: 121), emphasis in original)

3 Quality as a travelling concept, from industry to family medicine

3.1 The historical context and development of modern quality thinking

The term "quality", defined as "the standard of something as measured against other things of a similar kind"[35], already emerges in Greek and Latin. Comparison, improvement, and perfection are thus by no means modern ideas of humane practice but, in fact, reach back to ancient history (Friedel 2007). There are many different ways in which the idea of medical quality can be traced historically. One could, for instance, start with the Greek physician Hippocrates of Kos' principles of medical ethics, known as the *Hippocratic oath*[36] and analyse how it influenced medical ethics

[35] http://oxforddictionaries.com/definition/quality [21.03.2012].

[36] The Hippocratic oath was formulated by the Greek physician Hippocrates of Kos (460-370 BC). It lists the central values in the medical profession at that time: practising medicine supervised by Gods, practicing medicine as an art, respecting teachers, the importance of medical socialisation and education, strong social ties within the discipline, patients' health, the prevention of death, the division of medical tasks, respecting patients' integrity, abstaining from harassment, the equality of all patients, trust and professional secrecy, sanctioning medical misbehaviour (Steinmann 1996). This oath established central and obliging values which have shaped medicine until today.

through the centuries. From this perspective, discussions of quality could be considered as a form of professional self-reflection. Or one might start in the 18th century and show how the body served as a site for social and political regulation, and how science and politics merged in what Foucault (2005, author's translation) has called *biopolitics*. This would result in analysing quality control as a form of *biopower* or as an instrument for biopower. While there are different prior ways in which this trajectory could be analysed and structured, and to which at times I shall refer, the trajectory that I present in this chapter starts in the 1940s,[37] because that decade marks the onset of *Total quality management (TQM)*, a "school of thought" that "recommends that organizations become 'continuously improving' organizations or 'learning organizations'" (Martin 1994: 144). Building onward from this turning point, I aim at illustrating the development of the quality notion into a key professional, political, and economic concept throughout the remainder of the 20th and into the 21st centuries. While I shall by no means present a complete picture, I will indicate which discourses and actors I consider as crucial for the analysis of current discussions of quality in Swiss family medicine.

Although key thinkers behind the rising industrial quality rationale have developed different approaches on quality control and thus have established different quality schools, they have shared the conviction that *continuous improvement* towards "perfection" is the road to economic success. Probably the most prominent of them was William Edwards Deming (1900-1993), "star student" and assistant of Walter A. Shewhart, the developer of *statistical quality control* (Busch 2011: 129). Departing from Shewhart, who developed his ideas about quality mainly around „things", „Deming quickly realized that the same ideas could be applied to management" (ibid.). With this purpose in mind, he elaborated the TQM[38] approach and introduced concepts such as *system thinking*, *cyclic interventions*[39], *efficiency*, *standardisation*

[37] For quality ideas and developments before the 1940s s. Busch (2011: 125ff).

[38] Deming elaborated TQM in the post-war Japanese auto industry. After his success in Japan, it was only in the 1980s that "Deming was rediscovered" in the United States. From then on, however, "'total quality management' was the most influential fad of the 1980s" (Micklethwait & Wooldridge 1997: 278). TQM caught Europe's interest in the late 1980s (Martin 1994).

[39] PDCA (plan, do, check, act) cyclus (Rudhart-Dyczynski 2003).

(through the elimination of variation)[40], and personal *commitment*. These concepts were guiding factors in the emerging quality rationale in health care. They were subsequently actively transferred to health care by medical actors. The most prominent among these was the physician Avedis Donabedian (1919-2000) who became the most influential actor in the health care quality movement. Deming and Donabedian are thus considered as the forefathers of the modern quality rationale in health care (Best & Neuhauser 2004, 2005; Rudhart-Dyczynski 2003). Today, most concepts of health care quality on the global as well as local levels implicitly or explicitly refer to their ideas.

Deming and Donabedian dedicated their work to the development of a broad operationalisation of the rationale for quality, eventually attaining the status of redeemers, "[h]eroes and martyrs of quality and safety" [41] (Best & Neuhauser 2004, 2005) or, to use a very common term in the quality community, "quality gurus" (Mouradian 2002: 1).[42] Deming is called a "genius" (Walton 1986), the "prophet of quality"[43], the "messiah of management*"* (Mouradian 2002: 93), and the "ambassador for quality improvement" (Best & Neuhauser 2005: 310). His leading function in the quality community is expressed in additional ways, for example through Deming institutes, Deming awards, Deming stamps[44], or sayings such as "spreading the Deming Word" (Walton 1986: 158) and "Demingized Company" (ibid.: 209). Among the various moments during my field research when I encountered such glorifications was one in an *EQuiP* summerschool in Ghent which I attended in summer 2011.[45] In his introduction, one of the summerschool organisers, a Belgian family physician, explained

[40] Busch (2011: 125) notes that "quality control was all about ensuring that standards were met and variation kept to a minimum". In this sense, "a 'good' product is one that is close as possible to the mean value desired" (ibid.: 127).

[41] This is the heading used by the *Journal of Quality and Safety in Health Care* for a series of articles that portrayed quality actors such as Deming and Donabedian.

[42] Interestingly, in his book *The quality revolution: a history of the quality movement,* Mouradian (2002) puts the term "quality experts" in quotation marks but omits them when writing about "quality gurus" (s. Micklethwait & Wooldridge (1997) for the analysis of guru thinking in fields of industry and management).

[43] http://www.managementwisdom.com/weddempropof.html [04.03.2011].

[44] http://www.deming.org [04.03.2011].

[45] *EQuiP Summer School 2011: Research and developments in quality improvement in primary care*, University of Ghent/Belgium, 28.-31.08.2011.

his interest in medical quality by first telling us that quality came into his life many years ago when his wife had a car accident in Spain. Her experience as a patient in a local hospital was so horrible that he started to become more interested in how good care might be delivered. He went to say that a book written by one of Deming's followers, Philip B. Crosby,[46] changed his life in this regard; his father had been a leading figure in implementing quality concepts in the cable industry. He therefore was acquainted with the industrial quality rationale early on, and began to transfer it to medicine after his wife's experience with inappropriate care. He added that the *Institute of Medicine*'s (2001) publication *Crossing the quality chasm: a new health system for the 21st century* was like a "bible" to him.

These examples illustrate that Deming and Donabedian added a transcendental and salvational meaning to modern quality thinking (Hamada 2000: 301). Not only were they glorified by the quality community, but also their own thinking about quality took on the aspects of a crusade. Reflecting on the importance of quality, they declared it as a good for humanity that would eventually lead to a better world[47], the "betterment of man" (Mouradian 2002: 85), and function as guarantor of "prosperity and peace" (Best & Neuhauser (2005: 310), quoting Deming). Correspondingly, Donabedian (2003: xiii) considered quality as a "noble cause", which demanded "love" as one of its basic requirements:

> Ultimately, the secret of quality is love. You have to love your patient, you have to love your profession, you have to love your God. If you have love, you can then work backward to monitor and to improve the system. (Donabedian, in an interview with Mullan (2001: 140))
>
> […] a religious, a transcendent element has crept into my thinking. The secret of quality, I wish to believe, is love: love of one's profession, love of one's fellow man, and love of God. (Donabedian 2003: 81)

[46] Crosby, inspired by Deming and his industrial quality concepts, became particularly famous for his "zero defects" approach (Crosby 1980). He was among the industrial "quality gurus", and has even been called "The leading evangelist of quality" in *TIME Magazine* (26 March 1984).
[47] http://www.deming.org [04.03.2011].

One interesting example of this strong, transcendental belief in quality control occurs in a passage on *Six sigma*, a quality management approach that developed out of Deming's *Total quality improvement* concept (Busch 2011: 131), and which also aroused the interest of health providers (Morton & Cornwell 2009: 428). It refers to the Judo vocabulary and its various belt colours to structure its quality hierarchy (Sklair 2001: 127). Followers of Six sigma are "true believers […] drawing other committed zealots upward with them […]. We are feverish on the subject of Six sigma." (ibid.[48]).

Obviously, the modern quality rationale has moved far beyond the initial conviction that it paves the road to economic success. In fact, Deming, Donabedian and their followers go on to discover a religious imperative at work in this rationale. Referring more broadly to the formation of global capitalist systems, Leslie Sklair (2001) considers such types of arguments as functioning within a broader culture that necessarily resorts to uplifting ideological underpinnings. In that perspective, Donabedian's hymn to the motives and outcomes of love in the management of quality also function like other, less specific instruments of persuasion:

> The viability of the [global capitalist] system absolutely depends on being able to persuade the masses that this culture-ideology makes sense and leads to happy lives for all. (Sklair 2001: 4)

Bringing this broader point to bear on the modern quality rationale, Sklair's focus on persuasion means that all of the actors involved need to be convinced about the necessity of quality control. As I will show later on in section 4.2.2, this internalization (Hamada 2000: 301) is among the preconditions for the establishment and maintenance of a *quality dispositive*. Some authors, for example, regard participation in the quality movement as a basic requirement for success and luck, and even for inclusion and survival. George Mouradian (2002: 233) closes his book by stating that „if organizations do not get their quality houses in order, they will not be part of the great American dream". Deming[49] uses an even more incisive formulation in saying that

[48] Quotation stems from the *General Electric (GE)* annual report of 1997.
[49] http://www.managementwisdom.com [04.03.2011].

"no one has to change, survival is optional". In her book *Flexible bodies,* Emily Martin (1994) points to the legacy of this perspective, describing how in the late 1980s and early 1990s changed economic conditions led to "Grow or die" as the credo of continuous improvement:

> In order to survive in this changed environment, a wide variety of human resource managers, consultants, and authors are advocating that American corporations must become like biological systems that successfully survive in nature. (Martin 1994: 208)

As we see in these quotations, systems thinking, originally an approach applied in science and here paired with a social-Darwinist argumentation (Bröckling 2000: 138), is being applied to the improvement and success of industrial processes. From a systems-thinking perspective there are no external enemies that make success impossible. Rather, the internal dynamics are responsible for either success or lack of success. In view of this, rapid changes (e.g. increasing changes of job, changing infrastructures, acceleration of processes) resulting from industrialisation and the spread of technology require an adaptable workforce and corporal as well as mental flexibilities. As a consequence employees are increasingly required to function like *complex systems* (Martin 1994: 142-159). This approach creates a desired workforce composed of "individuals […] able to risk the unknown and tolerate fear, willing to explore unknown territories, but simultaneously able to accept their dependence on the help and support of their co-workers. In a word, flexibility" (ibid.: 214). To reach this aim, employees are to be educated and trained to reach the best possible performance. Here, TQM serves as a way to reorganise, structure, standardise, and improve that performance. Using the example of an outdoor "Survival Workshop" that she attended, Martin (ibid.: 207-225) illustrates how companies made use of physical experience to incorporate this new quality rationale into their workforce: TQM is to be experienced physically in various tree climbing exercises, which are conceptualised in such a way that participants must react physically to constant and sudden change. For example, their feet suddenly lose contact with the ground, which serves as a metaphor for rapidly changing workplace conditions. In these exercises participants have to work on their readiness to assume risk, to improve their spontaneity,

creativity and ability to react. Martin experienced these exercises as falling from one unstable condition into the next, physically instilling the importance of flexibility. She quotes the workshop organisers: It is a "training through the body, not of the body" (ibid.: 217). TQM thus addresses employees as „whole people" (ibid.: 214), making demands not only on physical exertion but, more importantly, on an employee's commitment to staying in the game while facing continuous risk and unpredictability.

Setting aside the wilderness-camp-ordeal accent on continual adaptation to risk, a less fraught motivational quotient from this regime remains relevant for medical practice settings. Deming and Donabedian considered personal commitment as "the most important single requisite" of every quality initiative (Donabedian 2003: xxix) and the "commanding position" within them (ibid.: xxxi). In their view, quality awareness is something that starts to grow from below rather than being something imposed from above (ibid.: xxix). For this reason, Deming was convinced that the establishment of the quality idea could not work through direct pressure and top-down regulations[50], but only through a changed mode of thinking and performance on every level of the company. Because he was eager to generate quality awareness and conviction in every corner of the company workforce, he argued that employees should receive education, training and supervision that would have them become proud of their work in this bottom-up manner. Through this new philosophy, change is to be reached collectively (Deming 1986: 23f). Thus from its early days quality improvement was based on the idea of functioning in a systematic and continuous way through personal commitment. Recent quality programs have adopted this approach, emphasizing the importance of a social mobilisation toward quality thinking. They consider the "bottom-up" institutionalisation of a collective quality commitment in terms of a "social movement" as the precondition for successful quality initi-

[50] Deming felt uneasy about "standardizing people" for reasons of "individual evaluation", ratings and comparisons, because this would create, in his opinion, "a climate of fear" and not solve the system-immanent reasons of problems (Busch 2011: 131). Thus, his focus was rather on developing "a set of standards by which organizations might be judged" (ibid.: 132).

atives (Bate et al. 2004). This transfer from external control and top-down regulations to personalised quality commitment is crucial for the establishment of modern quality thinking. From this perspective, control is to be replaced by "pride of workmanship" (Walton 1986: 91). Already in an early article on medical quality called *A framework for good primary medical care – the measurement and achievement of quality,* the authors considered "the intellectual and emotional participation of the physician in setting and maintaining quality standards" instead of a "passive acceptance of standards that might result from a purely bureaucratic process of control" (Buck et al. 1974: 603) as fundamental requirements for the implementation of quality programs. In chapter 4 I will elaborate on my understanding of commitment as the result of a specific form of government, namely that of "conduct of conduct", which means "a form of activity aiming to shape, guide or affect the conduct of some person or persons" (Gordon 1991: 2). From this perspective, quality thinking is an "imperative of [moral and social] responsibility" (Giri 2000) and self-discipline.

3.2 The development of family medicine as a discipline in its own right

In order to understand what the establishment of the industrial-based quality rationale in health care has meant for family medicine, we need to have a closer look at its history, premises and reference systems. To analyse quality discussions in and about family medicine, it is important first to understand the conception of body and illness in this discipline, how this conception evolved historically, and how it is staged politically. It is on this particular history and understanding family physicians ground their position in the discourses on quality.

3.2.1 Early quality reports in the 1940s and 1950s

When the modern quality rationale started to expand in the late 1940s, Western medicine was very receptive to these new ideas, mainly for two reasons: the disruptions in medical ethics caused by Hitler's Germany, and the setting up of national health systems in the United States and Great Britain. Up to then, reflections on medical performance, professional ethics and normative principles were mainly dealt with

intra-professionally through various forms of clinical "self-control" such as "post-mortem examinations" (Bundesärztekammer & Kassenärztliche Bundesvereinigung 1996: 11, author's translation). The earliest example of this is the Hippocratic oath, which has had a long life through later adaptations, and throughout the professional codices of the various medical sub-disciplines.

World War II represents a massive disruption in the history of professional medical ethics. The misuse of medicine for ideological purposes in Hitler's Germany undermined the most crucial principles of the Hippocratic oath and resulted in a crisis in Western medical ethics (Kater 1989: 387f; Mitscherlich & Mielke 1995; Li 1996). This crisis of representation and credibility in medicine after World War II led to the urgent need to rethink medical ethics and to restore the image of medicine. After 1945, professional ethics discussions and a series of global medical ethics codices were initiated, such as the *Nuremberg Code* in 1947 and the *Declaration of Geneva* in 1948 (Möhrle 1996). These declarations contained ethical guidelines for members of the medical profession, as well as policies for sanctioning (exclusion from the profession) in cases of misconduct. Therefore, the post-war years mark the first time in the 20th century when the role of physicians was criticised, negotiated and reflected upon both inside and outside the profession. Additionally (or maybe because of it), there was a general openness in medicine "to new paradigms such as systems theory and psychosomatic medicine" (Wynne 2003: 225). Notably, the leading and still in-use *World Health Organisation* (*WHO)* definition of health was formulated in 1948, which considers health to be "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".[51,52]

In line with other Western countries, health costs in Switzerland increased rapidly after World War II (Lengwiler 2009: 173). However, in contrast to the developments

[51] Preamble to the Constitution of the *World Health Organization* as adopted by the *International Health Conference*, New York, 19 June - 22 July 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the *World Health Organization*, no. 2, p. 100) and entered into force on 7 April 1948. The definition has not been amended since 1948.

[52] Despite this broad notion of health and illness, it was criticised for not providing any instructions on how to realise and operationalise it (von Uexküll 1986: 1292; Richter und Hahn 2011).

of national health insurance systems in the Anglo-Saxon countries, Switzerland took a different path by maintaining a privately dominated and federalistic (decentralised) health insurance system (ibid.: 165). Martin Lengwiler (ibid.: 183) notes that there was no atmosphere of departure at all which he attributes to the delegated welfare state model. A crucial characteristic for this was the strong position of private actors, particularly the health insurance companies and the professional medical associations, and the delegation of health-insurance decisions to the cantons and communities. This created highly varying health-insurance models which the State found difficult to govern (ibid.: 183). I assume that the relative strength of private actors accounted for the fact that no large-scale quality programs were instituted – a situation different than those in the United States or Great Britain. It was only in 1996, with the revision of the Swiss health insurance law, that medical quality control turned into a public issue and subject to legal recommendation, as I will show in section 4.1. In the Anglo-Saxon world, on the other hand, the health-care scene after 1945 was reorganised through large-scale institutionalization processes, such as the establishment of the *WHO* in 1948 as part of the *United Nations* (McCarthy 2002), and the establishment of the first national health systems in the United States (Falk 1946) and Great Britain (Greenhalgh & Hurwitz 2005a: 22). Up to the present, these two countries have a leading position in terms of reorganising health-care systems, operations in which the broad implementation of quality programs is a central issue. Various authors have noted that the principle of medical quality control started its journey in the United States, then moved to Great Britain and Holland, aroused interest in Germany (Fassl 1977: 517) and from there eventually moved to Swiss medicine (Pflanz 1978; Plücker & Swertz 1982). It has entered Swiss family medicine "osmotically", as one of my interview partners (Dr Lehner) put it. The same journey applies to other reorganisation concepts, such as the implementation of *managed care* or *diagnosis related groups (DRG)*. Interestingly, all these concepts "arrived" in the Swiss health system with a delay of about two or three decades compared to their emergence in the North American context. Again, this reluctance towards reorganisation might be explained by the strong position of private actors and professional associations in the Swiss context. It started to weaken only from 1996 on, when the Swiss health insurance law was revised and challenged these same authorities. The leading function of

the US American, British, and Dutch health-care systems in terms of medical quality control (Contencin et al. 2006: 65), and the role of Germany as a transmitter of ideas to Switzerland, accounts for my regular practice in this thesis of referring to discussions from these other national contexts.

The implementation of the *National Health Service* (*NHS)* in Great Britain led to fundamental changes, such as the credo to "provide health and social care for every citizen" (Greenhalgh et al. 2005b: 22), and the shift of treatment costs from (insured) patients to the State. This development is linked not only to increased access to medical treatment but also to enhanced governmental regulation and control of health care and, consequently, of health care professionals. Medical quality thus became an important argument for sound "planning" of national health systems (Subcommittee on Medical Care (American Public Health Association) 1949: 898). In this context the increasing division of medical specialties and the position of family medicine as an independent medical discipline within the health care system were discussed (NN 1950: 589). Therefore, for the purposes of my argument, this early link between transformations of the health care system, discussions on medical quality, and family medicine's positioning as a discipline in its own right is important and will be taken up in the Swiss context.

During my research about the onset of broad and systematic quality discussions about family medicine, I discovered a series of quality reports, all of which were carried out in the United States and Great Britain between 1949 and 1953. Their approaches can be distinguished by two kinds of thinking and writing about medical quality, one focusing on scientific aspects, measurement, planning and control of the discipline, the other portraying family medicine and reflecting on both its basic principles and ethical aspects. These twofold perspectives on medical quality were played off against each other; consequently they have formed a pattern which has remained a source of tension up to and including current discussions of quality in Swiss family medicine.

The first time that quality of care became an issue in the *American Journal of Public Health* was in 1949 in the context of the planned *National Health Program*. The re-

port *The Quality of Medical Care in a National Health Program* (Subcommittee on Medical Care (American Public Health Association) 1949) was a statement about the future path of American health care. Already in the introduction the authors declare their understanding of quality:

> The quality of medical care depends upon more than intangible, philosophical attitudes or particular personality traits on the part of those who render services. More is involved also than the technical content of the individual practitioner's work-basic as this may be. A high standard of care includes very definite scientific and organizational elements which can be incorporated into planning and which eventually will submit to measurement. (Subcommittee on Medical Care (American Public Health Association) 1949: 898)

This citation not only illustrates the manifold possibilities of defining quality, but it also places emphasis on definitions of quality which can be objectified, standardised and operationalised. This clear focus on measurement and control (planning) of health-care services clearly reminds us of the industrial quality concepts named earlier. The fascination with these concepts is revealed even more strongly in the report's list of quality requirements (ibid.: 899):

- Able, well trained, and efficiently functioning personnel.
- Facilities and equipment which meet high technical standards.
- Health services which encompass the best knowledge of modern medical science, and which ensure availability and continuity of care.
- Adequate financial arrangements, making possible the timely provision of all indicated services, without economic deterrents for patients or practitioners.
- Sound administrative organisation and operation designed to promote efficiency and economy of service.

As I will show later in this chapter, discussions of quality in the late 1940s were not so different from current ones. Promotion of quality, for instance, should run through sound education, careful selection of medical students, postgraduate education, institutionalised collaborations with other general practitioners and specialists (e.g. in group practices), clearly defined areas of responsibility, general practice as a pillar of the primary health-care system, capitation or salary payment (as opposed to fee-for-

service), "incentives to encourage doctors to settle in rural areas", and the necessity of medical audits[53] (NN 1950: 590).

In comparison to the American case, controlling medical quality was an idea completely new to British colleagues, as their discussion of the *Subcommittee on Medical Care*'s report illustrates:

> The unusual suggestion is made that qualifications of licensed practitioners might be reviewed periodically so as to safeguard the quality of care provided. (NN 1950: 589)

Despite some initial astonishment, however, the American report caught the spirit of the time also in Great Britain. In 1950, one year after the original report appeared, the so called *Collings report* was published (Collings 1950). In his highly critical, ethnographically conducted report on post-war British family medicine, the Australian physician Joseph Collings raised strong criticism against family medicine, accusing it of a lack of structure and standards, and of ethical misconduct (Sturmberg 2007: 39). He concluded that "[t]he overall state of general practice is bad and still deteriorating" (Petchey 1995: n.p.). His report painted a picture of the major difficulties that family medicine faced at that time: "marginalisation, exclusion from hospitals, declining status" (ibid.). The responses were bifurcated. Some supported Collings' critique about the desolate state of family medicine (e.g. Honigsbaum 1972: 433), whereas others strongly denounced it (Hadfield 1953; Taylor 1954). Nevertheless, it initiated a discourse on the status of family medicine and thus had a catalytic yet unexpected effect in turning the media's interest towards it. This proved to be important for the foundation of the *College of General Practitioners*[54] in 1952 (Sturmberg 2007: 39). In addition, the *Collings report* incited family physicians to present a different picture of their discipline (Stevens 1977: 455), which resulted in counter-reports, the most prominent ones among them being the *Hadfield report* and the *Taylor report*.

[53] Medical audits were based on morbidity and mortality rates and served "for self-education and improvement, for evaluation of new procedures, and for the discovery of sources of poor work in the institution" (NN 1950: 590).

[54] Later renamed as *Royal College of General Practitioners*.

The *Hadfield report* (Hadfield 1953) resulted from a research contract, aiming at assessing "shortcomings, faults, and difficulties" (ibid.: 683) that arose after the implementation of the *NHS* in (particularly rural) British family medicine. Also, this report was conducted through participant observation and provided quite contrary insights compared to those of Collings. In his conclusion, Hadfield provided the following definition of quality:

> In the category "good" I placed those practitioners whose skill was evident and whom I found exercising a constant care and thoroughness with every patient, a keen appreciation of the whole man in the patient, together with a friendliness and spirit of kindness and helpfulness. […] On the other end of the scale is the practitioner whose sole object appears to be to "get through" his patients with as much dispatch as possible, and to limit services given to the bare essentials. He does not, as a rule, appear to give satisfaction to his patients. He supplies them with a bottle of medicine, and that quickly. He is rarely concerned with anything below a full list, and would, I believe, prefer to give the service he is giving to a large number of patients than offer a wider and more thorough range of service to a smaller number for the same remuneration. (ibid.: 705f)

The *Taylor report*, published in 1954, supported this direction of impact and was later even considered the "bible" of family physicians (Stevens 1977: 455). In the foreword it is noted that Stephen Taylor was commissioned "to conduct a non-statistical survey of a number of practices of general practitioners, recognized as good doctors by their colleagues, to see how far the lessons they had to teach could be generally applied" (Foreword of Farrer-Brown in Taylor (1954: xvii)). Therefore, building on a "detailed descriptive social research" (ibid.: 15), the aim was to draw a portrait of "general practice at its best" for didactic means (ibid.: 444). The report's prologue starts with narrative accounts of three cases which Taylor encountered in his investigation, and results in the statement that "[m]y little friend is a good doctor. He knows his patients and their illnesses, their homes and children" (ibid.: xxii). This view of family medicine as being closely attached to local environments is a recurring theme throughout the report. In his investigation, Taylor accompanied family physicians in their professional routine, reported about the physicians' clientele, workplace conditions and structure, and professional activities.

These three early quality reports chose an ethnographic approach for their investigations (Petchey 1995: n.p.). Keeping in mind the generally increasing interest in statistical quality control for reasons of comparison and benchmarking, the applied methods in these reports appear extraordinary. This seems to be even more so because Taylor, for instance, stressed the importance of ethnographic procedures *prior* to statistical approaches and drew a comparison between social-scientific observations and clinical observations:

> There are some people who look on statistical studies as the only valid kind of social science. This attitude is as illogical as that which despises statistics altogether. In all investigations involving man, and indeed in the biological world generally, there is a large field for accurate and thoughtful observation of structure, function, behaviour, and association; indeed this field ought to be covered properly before measurement and the application of statistics begin. […] Often, careful observation will demonstrate that there is no need for statistical study. The facts are obvious, without recourse to exact measurement or sampling. Almost the whole science of clinical medicine has been built up by careful and exact observation in the consulting-room, at the bed side, and in the post-mortem room. In the field of social science the principle has been the same. It may be said of statistics, and indeed of experiment, that their value really starts when observation has shot its bolt. (Taylor 1954: 15)

On the basis of their collected data the authors reflect on the characteristics of family medicine, on the daily work of family physicians, on the environments the patients are living in and on the function of family medicine against this background. Petchey (1995: n.p.) described this tradition of quality reports as "thick descriptions" produced in long-lasting participant observations, and thus classified them among "the first workplace ethnograph[ies]" in the British context. So, what we gain from these British reports are portraits and positionings of family medicine within the wider health system. They not only illustrate how medical quality became an increasingly important health-care topic, but also reveal the attitudes of family physicians towards the implementation of national health systems such as the *NHS* in Great Britain. With the example of the *NHS* we see that external control, time pressure and the fear of impersonal health service were among the reasons for family physicians' ambivalence towards it (Hadfield 1953: 706). In this respect, family physicians were afraid

that the *NHS* would change the core principles and tasks of their discipline (ibid.) and, eventually, threaten the profession's future:

> Ought general practice as we know it today to continue? Is it an inevitable result of the advance of scientific medicine that the place of the GP should be taken by a wide range of specialists working from a polyclinic? Or is it desirable that at least one general practitioner should persist? (Taylor 1954: 2)

The quality reports presented above thus illustrate how, in times of change, quality represented a symbol used for debates about professional boundaries, reference systems, autonomies, and interests. For this reason I will now focus on the period of professional self-constitution, when family medicine aimed at the development of emic key concepts and at the representation as a discipline in its own right.

3.2.2 Defining family medicine and its professional boundaries

Already in these early quality reports, but especially in the ones from the 1970s, it becomes evident how medical quality served as an issue under which family medicine as a discipline in its own right was negotiated. The lines of argument were based on the definition of family medicine against other medical disciplines, and consequently, on the setting and maintenance of professional boundaries. These reports and articles thus set up issues that remained constitutive points of negotiation up to current discussions of quality.

As a consequence of technological and medical developments throughout the 20th century, medical specialisation took place at great speed (Samuelson 2009: 279) and created a vast array of medical sub-disciplines, among which family medicine was just one (Wolff 2008: 52f). Already in the early days, family physicians regarded specialisation critically, not least due to its increased attractiveness for patients and for the higher salaries of specialists (ibid.: 53). The establishment of quality control was thus regarded as a way to strengthen family medicine's position as point of entry into the health-care system (Buck et al. 1974: 599), and to legitimise family medicine's status as "a discipline in its own right", it being "no less precise than that of other fields of practice" (Parry 1975: 555).

The fast pace of medical specialisation required an even more complex reorganisation of health-care systems. In family medicine they were increasingly perceived as machineries that threaten the principles of medical practice, as Hadfield already noted in his quality report:

> Some [physicians] fear the evolution of general practice into some sort of a glorified hospital out-patient department where intimate knowledge of the patient, continuity of treatment, and the idea of the doctor as guide, philosopher, and friend are sacrificed to a hurried impersonal machine. (Hadfield 1953: 706)

Similarly, in my interviews the *machine logic* was often referred to when criticising the current health-care system. The metaphor of machinery was used, for example, to draw a line between hospital medicine as opposed to ambulatory care. Its main characteristics are called anonymity, missing importance of the family physicians' relations to their patients, missing influence of family physicians, overall check-ups as an expression of an unlimited medical practice, and the ignorance of patients' living environments. The interviewed family physicians used different metaphors for the description of this health machinery, such as "mill" and "carousel" that are "just running" (Dr Isler). In doing so, they emphasise their loss of control as soon as their patient enters this machinery. They perceive their role as being reduced to the one of a "station inspector" responsible for the "working of the switches" (Dr Odermatt), and who is excluded as medical actor when his/her patients enter hospital settings, be it in terms of decision making, the reception of updates, or information about treatments. In these situations, they perceive the patient as being dragged back and forth between specialists and family physicians. They consider it their duty to assist the patient in decision making that corresponds with his/her living environment. An interview partner mentions that losses of patients to the "machinery" "destroy you, they are very depressing" (Dr Odermatt). So, the metaphor of the machine was and still is used pejoratively to characterise mechanisms in health care that are not in line with family physicians' values and priorities.[55]

[55] Only in one of the analysed early quality reports is "machinery" applied in a positive manner (Williamson 1973: 697).

In early quality reports but also in current discussions, specialist medicine is defined as a constitutive part of this machinery. In this respect specialist medicine is used to define what family medicine and its quality principles are *not* about. *Othering* specialist medicine thus serves the purpose of defining the professional *self*, family medicine. The image drawn of specialist medicine is one that fragments the human body into separate parts (von Uexküll 1986: 1280f). Family medicine, on the other hand, applies a "whole-person orientation" (Mansfield 1973: 887f), and thus represents a "whole-person medicine" (Parry 1975: 554). By highlighting this orientation on the "whole person" (Jeffs 1973: 683) in his study called *Being a good doctor*, Jeffs (ibid.: 685) emphasises that "in every illness the psyche and the soma work hand in glove". Consequently, *uniqueness* was constructed as a key concept of family medicine:

> Each *illness* caused by a given disease is unique, however, and differs from every other illness episode because of the *person* in whom it occurs. Even when a disease recurs in the same person, the illness is changed by the fact that it *is* a recurrence; it now carries the associations and the history of the previous episode. (Cassell 1984: 34, emphasis in original)

Uniqueness not only comprises the diversity of patients and their various health concerns and environments, it also refers to the particularity of each physician (Jeffs 1973: 685, 690), of each practice, and health system.

Jeffs stresses that in family medicine the long term relationship between family physician and patient create working conditions that are very different from those of specialists:

> The family physician sees the same patient over and over again with different diseases. He therefore gets to know more about the patient than the disease. The specialist sees the same disease over and over again in different patients. He therefore gets to know more about the disease than the patients. But the general practitioner's awareness embraces a greater portion of humanity than the individual in isolation. He knows the patient's family, his home, how he chooses to live, the colour of the wallpaper in the hall and the dog's name. While the specialist's diagnosis is specific to the illness the general practitioner's diagnosis is relative to the patient's circumstances, to his family, his employment and his whole way of life. (Jeffs 1973: 686)

In line with this statement, Mansfield (1973: 889) draws the conclusion that family physicians and medical specialists in fact belong to two different kinds of medicine, the former to a „person-oriented medicine“, whereas the latter represents “disease-oriented specialties”. Accordingly, it was stated that family physicians depend on different instruments than their colleagues because they are very often confronted with rather “undifferentiated symptoms […] than with clear-cut diagnostic entities” (Buck et al. 1974: 603). Buck (ibid.) thus claims that “primary care needs standards that begin with the management of fever, irritability and earache in a child rather than with the care of streptococcal otitis media”. So, already in these accounts from the 1970s we see that quality discussions were used as a platform to present what were considered the characteristics of family medicine. During my field research this strong link between representations of family medicine and perceptions of medical quality was strongly accentuated. In relation to the way of reasoning that is apparently typical for family medicine, a retired doctor told me that in family medicine it is of crucial importance to think “in reversed order” (Dr Lehner):

> If you come to my practice I don’t read „pneumonia“ on your forehead. Rather, you show signs and symptoms of a possible pneumonia and it is up to me to channel them with good questions. (Dr Lehner)

Another interview partner compares his experience as family physician against that of an endocrinologist, a comparison that reminds us very much of quotations mentioned above: He stresses that in family medicine, the point of departure is the patient. He is the doctor’s “raw material” (Dr Debrunner) on whose basis he moves towards a diagnosis and treatment:

> You may try to proceed systematically and realise all of a sudden that, even though you know how to proceed with a diabetic, he might not want it. He might think about something else or never shows up anyway. Accordingly, you have do reconsider from case to case what the smart next step would be, without removing oneself too far from what one ought to do. And that you, conversely, leave the patient his individual path. (Dr Debrunner)

The patient’s suffering might point in various directions, and it is the family physician’s task to localise its origin and meaning. In this context, the family physician’s

knowledge is described as broad. In endocrinology, as my interview partner underlines, the point of departure is a narrow and pathological focus: The specialist has to find out what the patient suffers from in the field of endocrinology. To do this, he/she depends on a profound endocrinological knowledge. The interviewed doctor passed one of his assistant years in an endocrinology department, and recounts the following:

> I realised that you simply check up on the patients and look to what extent they fit into your system [endocrinology]. On the one hand this is quite appealing, you're always appreciated and earn double money for your work. I don't mean to say that we don't also need that kind of work, but it was never an option for me. I perceive it as too simple, too uninteresting. Just always checking if it [patient's suffering] belongs to your system. […] Basically, I came to realise that I like it best when someone comes and suffers from something, and it's up to you to reflect about what's wrong here. This is the form, the situation that's most interesting. (Dr Debrunner)

Already in earlier quality reports this perspective was, of course, linked to particular ideas of medical quality that pay attention to things such as "putting the patient at ease", "the art of listening", "what the symptoms mean to the patient", "what the symptoms mean to the doctor", "what the symptoms mean to the patient's family", "mutual trust" and "being involved" (Jeffs 1973: 683ff). Such quality features were used as a means to illustrate family medicine's advantage against medical specialities. Jeffs (ibid.: 686), for example, attributes to family medicine "a greater portion of humanity". Followers of Georg L. Engel, father of the biopsychosocial model[56], are an additional, still later, example of this. They transcended his approach and applied terms such as "believers", "non-believers", "preaching", "converts", and "sceptics"

[56] George L. Engel aimed at the extension of the biomedical model because he considered, as Frankel et al. (2003a: 25) recount, a human being as "both a biological organism and a person who lives in the context of family and community". In order to illustrate the relationships between cells, organs, and the apparatus of a living organism and the relationships between the organism and its environment, Engel and his followers abandoned linear, dualistic models and proposed a circular, system-minded, and tripartite approach instead: the *biopsychosocial model* (Adler 2005). Engel's and Balint's approaches were manifestations against the "static spatial concepts […] permanence and uniformity" (Cassell 1984: 53), and instead made claims for a processual and variable understanding of health and illness.

(Dombeck et al. 2003: 241). Furthermore, former students and "devotees" wish to "'spread' it to others […] like cells metastasizing from the primary site to faraway places" (ibid.: 242). In their conclusion the editors state that they "are advocates and champions for a biopsychosocial approach and believe the weight of evidence makes it the best choice to teach and research" (Frankel et al. 2003b: 265). This statement and many others, including physicians' statements in the interviews, illustrate how discussions of quality serve as arenas where these diverging approaches toward patient and illness are compared to each other and translated into definitions of "optimal" care that often circle around normative questions such as: What is *real* medicine? What is *good* decision making? What is the *best* choice?

The construction of boundaries between "them" and "us" implied family physicians' entitlement to setting the definition of medical quality. In the 1970s authors thus stressed the necessity of creating an emic view of quality that takes into consideration "the essence of general practice" (Mansfield 1973: 893) and involves physicians as experts on medical practice, "for only they can determine appropriate levels of demonstrable competence and define the limits of acceptable practice within which innovation and experiment can take place" (Parry 1975: 552). Consequently, criticism from non-practitioners was regarded suspiciously. In his critical literature review, Honigsbaum (1972: 432–440, emphasis in original), himself not being a doctor, pointed out a decreasing quality in family medicine, characterised as follows: shortage of time due to a decreasing number of family physicians and an increasing number of patients, unwillingness of British family physicians to work longer hours, a high percentage of them older than forty years[57], as well as missing attendance at "refresher courses". In explaining the last argument, Honigsbaum makes the interesting remark that working experience and continuous medical education (CME) have almost no effect on quality. He emphasises that, on the other hand, "[f]ar more important is the length of education a doctor receives *before* he enters general practice". He continues with his long list of failures that are responsible for the low quality of care in family medicine, ranging from "failure in preventive medicine and early di-

[57] „[T]he age of the practitioner is a key factor: the older the doctor, the poorer his care tends to be" (Honigsbaum 1972: 432).

agnosis", to "clinical failures", "deficiencies in equipment", "poor [medical] records" keeping, to "poor referral letters". Honigsbaum's critical literature review was not well received and was pejoratively called the "opinions of a research scientist" who "has fallen in the trap of misinterpreting statistics, selecting data and frequently quoting out of context in order to prove his case" (Marson et al. 1973: 23). Furthermore, he "lacks the necessary knowledge of the natural history of disease to be able to interpret this type of data" (ibid.: 24).[58]

However, despite the various attempts to reach a general understanding of medical quality, authors noted the absence of a common notion of what optimal care is (Mansfield 1973: 887). This might explain why they were thus very receptive to American discussions of quality and adopted their orientation from Deming's core principles of *efficiency* and *effectiveness* (Buck et al. 1974: 599, 602; Williamson 1973: 706; Parry 1975: 552) and Donabedian's division of quality into *structure*, *process*, and *outcome* (Buck et al. 1974: 599, 602). In the light of current quality regulations that are often considered as being governmentally induced, it is very interesting to see that at that time actors from family medicine themselves pushed concepts such as *medical audit* and *quality control* and proposed the application of quantitative measurements (Williamson 1973: 706; Parry 1975: 552; NN 1969: 331). An evaluation elicited at that time illustrates how these management approaches towards quality (here illustrated by Deming's understanding of variation as waste[59]) were applied in evaluations of family medicine: In the late 1960s a doctor from New Zealand conducted an evaluation of family physicians' quality by distributing a ques-

[58] Also in current quality discussions, the distinction between "us" and "them" is remarkable. By drawing this line, family physicians do not distinguish between doctors and non-doctors, but rather between practically oriented actors and actors detached from medical practice. The latter group is not necessarily limited to people working for health insurance companies or federal offices but may also include family physicians who work for such organizations. An interviewed doctor, for example, complained about colleagues who are working as medical examiners for health insurance companies by calling them "armchair professionals" who are "far away from patients" (Dr Frei). In the context of current quality discussions I noted that representatives from family medicine often overstate such dichotomies and thus use them as a means for self-representation and self-positioning.

[59] Deming emphasised that variation is the cause of waste and should thus be eliminated in order to reach uniformity of production and products (Best & Neuhauser 2005: 310).

tionnaire that was based on the following seven common clinical conditions (NN 1969: 332):

- "An acute coronary thrombosis, seen two days afterwards for the first time.
- A middle-aged patient coughing up blood and complaining of shortness of breath.
- A patient complaining of rectal pain on defaecation.
- Management of the chronic alcoholic.
- Management of chronic obesity.
- An engaged couple requiring advice about family planning.
- The widowed mother of several children with numerous complaints."

The physicians were then asked to think about patients from their own practice with similar conditions, and to describe how they treated them. The results showed that every condition was managed differently by the surveyed physicians. What was emphasised in my research as a core principle of family medicine (Abraham 2010; s. also Mabeck & Kragstrup 1993) was then, in fact, used as a critique of it (NN 1969.). This and many other studies explicitly or implicitly applied Deming's rationales, which emphasise the crucial importance of measuring, controlling, and finally eliminating variation with the help of statistically based quality standards (Best & Neuhauser 2005: 310). As one might expect, this perspective on variation was severely criticised in many of the quality reports of the 1960s and 1970s. For instance, one of the first German articles dealing with the application of industrial quality principles to family medicine illustrates this allegorically:

> The industrial production of meals leads to an end product in which all portions must be interchangeable; but the appeal of the home-made meal lies somewhere else, it is more individual and can adjust itself to all possible requirements without having to abandon "recipes" or "standards". A housewife will not take it as a compliment when one tells her that her roulades taste "like canned". (Aeffner 1968: 522, author's translation)[60]

[60] The article was a reaction to the inaugural lecture of Manfred Pflanz (1968) called *Beurteilung der Qualität ärztlicher Verrichtungen*. In it the German medical professor Pflanz who worked under Thure von Uexküll (founder of psychosomatic medicine) and who later became a famous representative of social medicine and epidemiology, proposed the application of industrial concepts to family

Therefore, parallel to the rising interest in industrial reasoning in medicine, counter-discourses were established that strongly criticised the assumption of average bodies, average and mono-causal illness episodes, and predictable and measurable treatment outcomes. In a more recent article called *What's the difference between a hospital and a bottling factory*, Morton & Cornwell (2009) argue that factors such as variability of patients, diagnoses and contexts, subjectivity of medical practice and decision making, interdisciplinary collaborations, as well as subtle aspects of care, the patient-doctor relationship, and authenticity render the comparison to bottling factories inadequate. They emphasise that the diagnosis and treatment of patients cannot be "mapped out in advance" in the way that "the path of a bottle through the factory" can (ibid.: 339). They continue by saying that "the only way to eliminate variability completely would be to eliminate patients" (ibid.).

3.2.3 Global family physicians movement: *Wonca* and its quality mission

The blue bags invasion is the picture I remember best when thinking about my participation at the Wonca[61] conference in Florence, Italy in 2006. Around 3'000 participants from around the world invaded Florence, being visible with the blue bags received by the conference organisers. These blue bags functioned as a corporate and collective symbol for their profession: family medicine. Although physicians came from various countries - in the course of the conference I got to know people and projects from England, Brazil, The Netherlands, Israel, Germany and Iceland – the blue bags marked their common ground performatively. Participants enthusing about the conference stressed that Wonca is a big global family, and Wonca conferences – despite their large size – are some sort of family reunion. (Fieldnotes,2 September 2006)

The global professional movement *Wonca* was founded in 1972 in the context of the above-mentioned discussions of quality and accelerated the establishment of family

medicine and with it provoked decided and emotionally driven counter arguments from his colleagues (e.g. Aeffner 1968).

[61] *World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians*, or in short: *World Organization of Family Doctors*.

medicine and its recognition as a discipline in its own right (Cassell 1997: 4f). The establishment of *Wonca* was thus inextricably linked to particular ideas of quality (Samuelson 2009) and to the creation of categories thereof. In this respect, *Wonca* bases its quality "agend[a]" on the definition of family medicine.[62] From the very beginning, quality improvement was considered as a necessity to "justify its [family medicine's] position as the foundation of the health care system" (Mäkelä et al. 2001: 26), to educate family physicians for quality improvement and to serve as an orientation in the "quality wilderness" that started to emerge (ibid.: 14f).

In 1989 members of *Wonca* founded *EQuiP*, the *European association for quality in general practice/family medicine*[63]. The representatives listed their aims as follows[64]:

- "To revise the current state of quality indicators and standards in General Practice in the member countries
- To take measurements
- To get to know the capacity of the member countries to improve them
- To draw up methods by way of which Wonca could promote the set-up of quality improvement strategies"

In line with *Wonca*'s wish to build a worldwide network of family physicians, *EQuiP* aimed for a quality mission that would travel around the globe, metaphorically infecting all its members:

> Primary care quality improvement started out first in Western Europe, North America, and Australia, and now primary care professionals all over the world are beginning to catch the travel bug as well. (Mäkelä et al. 2001: 15)

This quest for a worldwide quality standardisation requires a body of experts who teach the "state of the art" to the various countries and thus promote the establishment of local quality programs. To reach this aim, *EQuiP* built up a network of actors that promote their ideas about quality through working groups, conferences, pub-

[62] The definition is to be found at http://www.woncaeurope.org/Definition%20GP-FM.htm [25.05.2012].
[63] *EQuiP* is a sub-group of *Wonca Europe* with 29 member countries; online at http://www.globalfamilydoctor.com/publications/news/november/07.htm [25.06.2010].
[64] http://www.equip.ch/flx/about_equip/short_history_of_equip/ [29.11.2010].

lications, research and evaluation institutes, assessment tools, and summerschools. *EQuiP* thus institutionalised *Wonca*'s quality rationale and actively contributed to the establishment of a certain kind of quality discourse in family medicine. Today, *EQuiP* protagonists operate in various countries and could best be described as "locally-based globalizing professional[s]" (Sklair 2001: 131), all following the same quality mission. In Switzerland, *EQuiP* is represented by *Swisspep* who describes itself as an "international and national network of quality experts"[65] (author's translation).

In 1992 *EQuiP* published its mission in the form of a report called *Quality assurance for family doctors* (Marwick et al. 1992), which nine years later was revised and republished under the title *Family doctors' journey to quality* (Mäkelä et al. 2001[66]). The authors of the latter conceptualise quality metaphorically as a lifelong personal journey toward perfection (ibid.: 20) where the journey is more important than the goal:

> Travel is a personal experience. It encompasses more than a means of transport; it is more than simply getting from one point to another. While the airline flight, sea voyage and ground transportation are important aspects of travel, so are the food, lodging, personal encounters and other unique occurrences we experience as travellers. Our expectations, cultural background, financial resources, personal interests, and elements beyond our control (such as weather or accidents) are key factors in our valuation of the journey. […] Quality is not the destination; it is a never-ending journey. Quality improvement and management in primary care, as in any other field, are continuing processes instead of programs run once and then forgotten. Quality can never be fully reached in health care; it is like the Nordic saga castle of Soria Moria on our book cover. Although aspiring travellers can clearly see its towers, it is so wonderful that they somehow cannot describe or picture it. And as they climb the next mountain range, the castle hovers ever further in the air, shining golden in the distant blue hills. (Mäkelä et al. 2001: 9)[67]

[65] http://www.swisspep.ch/ueber-uns.html [10.08.2011].

[66] http://www.globalfamilydoctor.com/aboutWonca/aboutWoncaHistory.asp [25.06.2010].

[67] The narrative and metaphysical sections in the report discussed above are combined with a rather "classical" quality vocabulary, dropping terms such as "best health outcomes" (Mäkelä et al. 2001:

The "never-ending journey" of quality improvement is, of course, the core idea of "continuous improvement" (Donabedian 2003: xxiiif). This includes "all actions taken to establish, protect, promote, and improve the quality of health care" (ibid.: xxiii). As a consequence, actors should "observe, interpret, do something, assess what you have done, and never rest!" (ibid.: xxviii). So, quality is not a state but a constant journey on a continuum towards perfection. On this "quest for perfection" (Sklair 2001: 125) "no level of quality can be fully satisfactory; one should always try to do even better, progressing to ever higher levels of goodness" (Donabedian 2003: xxiv). This principle is mirrored in physicians' earlier[68] as well as current accounts of medical quality. A female doctor told me that "[t]o be a good doctor is an ambitious goal which you can never cope with" (Dr Christen).

Clearly, Donabedian and Deming had a strong influence on *Wonca*'s quality mission. Not only did Mäkelä et al. (2001: 22) adopt Donabedian's "quality cube" and his conceptualisation of quality as structure, process and outcome (ibid.: 21, 26), they also apply ideas such as continuous improvement, standardisation, best practice, excellence, application of statistical quality control, and elimination of waste (ibid.: 32). While reading this I was particularly interested in the report's position towards variation. The authors distinguish between legitimate reasons for variation ("individual patient diversity, ways illnesses develop, unequal resources or uncertainty about the best medical practice in certain situations") and "less acceptable causes" for it such as "inadequate knowledge or skills, poor management and delivery structures, or ignorance or disregard for well documented evidence of best practice" (ibid.: 27). Although the 2001 report emphasises that quality standardisation has to pay attention to variation in terms of "local appropriateness", and "resources, environment, attitudes and culture" (ibid.: 54f) of quality improvement programs, I found this claim to

21), "doing the right things right" (ibid.: 19), "continuous improvement" (ibid.: 69), "perfection" (ibid.: 20, 145), "excellence" (ibid.: 3, 39), and "best practice" (ibid.: 10, 27, 139).

[68] "The fact that a patient's illness includes factors far beyond the signs and symptoms of a discernible organic disease is not an excuse for ambiguity, but a call for the continued search for understanding its nature. For it is within the questing spirit of a caring profession that the true quality of medical care lies." (Parry 1975: 556)

be an extremely difficult one. Both in 2008[69] and 2011[70] I visited *EQuiP* summerschools that dealt with quality improvement in primary care. Not least due to the heterogeneous composition of these summerschool groups, the question of variation and variability remained a concern that was not always discussed in a satisfactory way. In Nijmegen I noted:

In summer 2008 – in the sense of doing participant observation – I visited a summer school in Nijmegen, Holland called "Quality Improvement Research in Health Care". This summer school was organised by the leading European actors of quality improvement research in health care, most of them being originally trained as family physicians. The participants came from various disciplines and countries around the world – Belgium, The Netherlands, Germany, Denmark, Slovenia, Iceland, Switzerland, France, and even Lebanon and Indonesia. And all had the same goal: to learn about "best practice" and the measurement of medical quality. Generally speaking it was all about developing quality indicators out of medical guidelines. I was deeply astonished that quality improvement was such a global issue. And – as I notice now from a distance – not just global, but globally circulating. Quality, at first sight, represented a common language and interface between the participants and was the reason that brought them there. Yet, when we had to do exercises and develop quality indicators in small groups, this apparently common language disintegrated and the heterogeneity and vagueness of the term became apparent. It became quite clear that every participant was linked to specific local living and working contexts which all related to very different, ethnocentric quality definitions and discussions. I particularly remember the Lebanese participant who told me that in the hospital where she works, it is the grand piano in the entrance hall that marks the quality of the hospital, standing for wealth, sophistication and seriousness. Another crucial insight came from the fact that in the exercises, matters related to local contexts, conditions or patient perspectives functioned as obstacles to the development of indicators. So in many exercises we ended up with reducing reality to fragments, i.e. manageable

[69] The *Summerschool on Quality Improvement Research in Healthcare* took place at the *Scientific Institute for Quality of Healthcare* at *Radboud University Nijmegen/NL*, 25.-29.08.2008.
[70] S. footnote 45 for information about this summerschool.

and measurable bits and pieces. As we learnt, the intention of the quality movement is, first, to reach a worldwide quality standardisation, and only second, to include local conditions, structures, know-how etc. During my study I came across this universalistic claim in other contexts as well. When I tried to focus on the relationship between medical guidelines and the heterogeneity of both patients and physicians (living and working conditions, local environment, illness trajectories etc.,) in the last question-and-answer session one of the organisers rolled his eyes and said "Oh, it's you again with your philosophical questions". That was his response to my question, and while the other participants felt amused about his comment, I understood that my question opened up a black box that the organisers wanted to keep locked. When I visited my second summerschool in Belgium this black box was part of my luggage. When I introduced myself to the group of participants I noted that one of the interests that brought me to this event were my open questions about the standardisation of illness trajectories and physicians' treatment thereof. I expected some kind of uneasiness on the organisers' side but was, instead, told that this is a question that they find extremely important to ask. Consequently, the summerschool did not focus so much on a universalistic approach but opened the floor to the participants' local experience with improvement of practice. (Fieldnotes, 30 August 2008)

3.3 Early quality discussions in Swiss family medicine

Probably one of the first German physicians who tried to introduce a modern quality rationale to medical performance was Manfred Pflanz (1923-1980). He criticised the autonomy of medical professionals in controlling their work and stressed that physicians should not stick to their special status anymore but instead make their work transparent with the help of quality assessments (Pflanz 1968: 1945–1949). Although the professional medical associations aimed to control physicians' work through titles, further education, and courts on professional conduct, Pflanz (ibid.: 1945f) identified three drawbacks:

- The lack of quality criteria on physicians' work.
- The exclusion of outsiders (medical associations, colleagues) from the greater part of medical work.
- Limited power of the medical association.

However, the reflections which he expressed in his inaugural lecture in 1968 remained unheard (Pflanz 1968; Aeffner 1968). In the decade after his lecture, quality control did not arouse anyone's interest – at least in the ambulatory setting (Pflanz 1978: 10). Only in the late 1970s did discussions of quality increasingly target questions of medical treatment and professional performance, due chiefly to the transforming status of medicine. American sociologists started questioning physicians' extraordinary status and initiated critical discussions on professionalism. In his essay *Qualitätskontrolle in der medizinischen Versorgung*,[71] Alfred J. Gebert (1980: 128, author's translation) considers this "entering of the social sciences[72] into the field of health care" as one main reason that led to the establishment of medical quality control in the United States (ibid.: 128). Even though physicians – among them Donabedian – were very influential on research about medical quality,[73] Gebert (ibid.: 129, author's translation) points out that only the social sciences' preoccupation with medicine established medical quality control as an ultimate principle and thus contributed to the "demystification of medicine". As an example of this transition taking place, the intra-professional quality activities physicians have been organizing autonomously for centuries were increasingly challenged by non-professionals (ibid.: 133). In an article written by a German physician we read that medicine is not a "free" profession anymore, and that traditional, status-linked special rights for physicians should come to an end (Fassl 1977: 517, author's translation). Other authors noticed an increase in the number of patients suing physicians in Germany. From this standpoint, quality programs were considered as preventive actions, but also as acts

[71] *English* Quality control in medical care.

[72] In relation to disciplines that were most influential, Gebert (1980: 129) lists health economy (Berry, Fuchs, Pauly, Reinhart) and medical sociology (Anderson, Freidson, Glaser, Levine).

[73] In Switzerland, Donabedian's predominance is expressed by the many journal articles that refer to his quality concepts, e.g. Naef (1981), Vetter & Lüscher (1983), Mössinger-Rey et al. (1989) or Gebert (1980).

of transparency on whose basis the adequacy of a treatment could be reconstructed (Plücker & Swertz 1982: 16).

So, in Germany and Switzerland, after an initial hesitation about quality control in medicine, the 1970s were eventually followed by a boom of publications on this topic. Now the establishment of medical quality control was regarded as inevitable due to its long tradition in other countries, as well as non-medical settings such as technology, administration and economics (Fassl 1977: 517). Medical representatives thus strongly argued for a pro-active role for the medical associations in preventing the imposition of external quality control (ibid.: 518), a position that was maintained up to current discussions of quality in Swiss family medicine. The first articles for the most part dealt with quality assurance in medical technology (e.g. X-rays), in laboratories, or in the pharmaceutical industry and thus focused on measuring accuracy.[74]

Apart from voices criticising medicine's autonomous status, also in Switzerland, the call for quality control was considered an effect of rising costs in the health care sector (Naef 1981: 3544; Plücker & Swertz 1982: 13; Gebert 1980; Sahli 1988; Zschokke 1981; Mössinger-Rey et al. 1989: 1279; Rehli 1985: 1717). Among the reasons listed for rising costs were: biomedical advances, rising claims for medical treatment, the growing number of medical students and physicians, a strongly developed social insurance system, increased interests and claims of patients, technical innovations in medicine, and the advancing age of the population (Geiser 1982: 884; Naef 1981: 3544). However, these authors and many others were sceptical that high health care costs could be reduced by quality control but would, in turn, even increase costs (Naef 1981: 3544). Beyond economic considerations, these early quality discussions in Switzerland also mirrored concerns about the decrease of family physicians' professional autonomy. In the 1960s political representatives of the Council of States agitated for the maintenance of the autonomous status of physicians, not least because of their decline in numbers. Yet, twenty years later the situation was

[74] E.g. Wieser & Etter (1976), Dubach (1975), Wisser & Knoll (1974), Hoppe (1972), Seubert (1972), Bürgi (1971), Pfeiffer (1971) or Naef (1981).

very different: due to the increased density of physicians, their professional status could now be challenged by non-professionals (Rehli 1985: 1716). In the late 1980s the former *FMH* president Hans Rudolf Sahli (1989: 17) noted that society in general no longer believes unconditionally in the competence of medical practice but asks for explanations and verifications. The rise of critical voices therefore has led to the disruption of professional autonomy, which has forced physicians to reflect increasingly on their medical practice (Sahli 1988: 800) and to provide those outside the field with insight into these reflections. Physicians' reactions to this change were mostly critical and expressed medicine's struggle with quality control as a balancing act between proclaimed necessity and professional self-responsibility (Jakob 1988: 799). Representative critical voices argued that there is no need for top-down, governmentally induced quality regulations which question the individual responsibility of Swiss physicians (Haase 1988: 14).

In addition to the reasons mentioned so far, I assume that it was also the relatively late institutionalisation of Swiss family medicine that delayed quality discussions. In the late 1950s and early 1960s, Switzerland's neighbouring countries were strongly promoting the institutionalisation of family medicine, whereas Switzerland remained rather passive (Meyer 1997: 1328). The *FMH* considered the institutionalisation of general practice with some reservation, fearing that it would divide the medical fraternity (Neumann 1987: 9; Meyer 1997: 1329). In addition, as a result of the federalistic structure of the Swiss health system, family medicine did not develop simultaneously in the different cantons but consisted of various smaller associations.[75] Despite the fact that the title *Arzt für Allgemeinmedizin FMH*[76] was established in 1966, Swiss general practice lacked a structure compared to other medical disciplines. In the years before 1965, family medicine was in turmoil because it was not considered to be a scientific, medical discipline in its own right. This turned it into an „almost under-researched medical field" (Rehli 1985: 1715, author's translation). Family

[75] The first societies for general practice were founded in the French part of Switzerland between 1953 and 1964. In 1965, the canton of Zurich founded the first society of general practice in the German-speaking part, followed by other German speaking cantons only eleven years later (Neumann 1987: 7).
[76] *FMH* title for general practitioners.

physicians felt increasingly marginalised and isolated (Neumann 1987). All medical specialties except family medicine were represented at the university faculties of medicine. Prospective family physicians underwent a specialty training[77] and were thus confronted for the first time with family medicine issues when entering medical practice, where they had to acquire knowledge in an autodidactic way (ibid.: 7). The decline of medical students aiming to become a family physician – an effect of this turmoil – caused nervousness among representatives of family medicine (Rehli 1985: 1715). Against this background, the introduction of the *FMH* title for general practice was linked to the hope to specialise family medicine (ibid.: 1716) and to change the economic discrepancies between the income of specialists and family physicians. Furthermore, it was hoped that the newly created title would enhance the prestige of family physicians, not least among medical students (ibid.: 1715). Sahli (1989: 17, author's translation) thus called this title a "quality feature". It not only served to mark the symbolic equality of family physicians with specialists, but also expressed professional approval for institutionalising specialty training tailored to the needs of family medicine (Flück 1985: 1719).

The foundation of the *Swiss society of general medicine (SGAM*[78]*)* in 1977 is thus to be seen in the light of family physicians demanding a specific curriculum for their speciality training. Additionally, among the association's aims were the institutionalisation of family medicine at universities, its recognition as a speciality in its own right, the conduct of research in fields relevant for medical practice, the promotion of interdisciplinary and international networks, services to its members, and the participation in prevention and public-health domains (Neumann 1987: 9). Furthermore, the establishment of a proper journal, the *Medicina Generalis Helvetica*[79], served as a newsletter for its members. In addition to the existence of an *FMH* title for general practice since 1966 (Neumann 1987: 7), and to the existence of smaller, cantonal associations of family physicians before 1977, the newly founded *SGAM* was sup-

[77] The medical education in Switzerland is divided in the following steps: basic medical education, state examination, 5 years of specialty training, obtaining of FMH specialty title, continuous medical education.

[78] *German* Schweizerische Gesellschaft für Allgemeinmedizin.

[79] 1991 integration of *Medicina Generalis Helvetica* in *ARS MEDICI* (Meyer 1998: 84).

posed to provide Swiss family physicians with a strong, unitary voice (Rehli 1985: 1718). None the less, the main aim of the *SGAM*, the academic institutionalisation of family medicine, only proceeded slowly. Only in 2005 was the first *Institute of Family Medicine* founded at the *University of Basel*, followed by the *University of Zurich* in 2009. In spite of these developments promoting the institutionalisation of family medicine, there was a continuous decline in family physicians since the mid-1960s (Flück 1985: 1719), so that in 1983 only about a third of physicians were family physicians (Rehli 1985: 1715). The threatening scarcity of future family physicians was the major reason for the first public demonstration of family physicians in 2006 and remained a key argument of the medical fraternities' position in public discussions (Späth 2005).

The transfer from quality control of X-rays and laboratories to quality control of medical performance and CME was controversially commented on among family physicians. One doctor, for instance, claimed that "self-responsibility" has the "highest priority", and criticised the emerging idea of controlling medical equipment as well as CME (Jakob 1988: 799). He continues:

> Exams until the end of life. Is the work of us physicians so bad, is quality so endangered that one must force us through quality control for continuous medical education and periodic testing? (ibid., author's translation)

Mandatory programs of CME were now criticised as the new instrument of quality assurance, ignoring the varying ways through which physicians acquire knowledge (ibid.). It was complained that a small number of colleagues who do not participate in CME are forcing more active physicians to undergo permanent examinations (Haase 1988: 14). In his article Naef (1981: 3545) notes that quality control of laboratories or X-ray machines is feasible, whereas its transfer to ambulatory care is almost impossible and does not provide a complete picture of medical practice. He stresses that the need of quality control to be precise and measurable puts it in a controversial relationship to medical practice:

> Being a doctor […] does not rely solely on the results and rules of the biological exact sciences. Medical work still remains an art, too, and always relies, as every art does, on imponderables, intuition and associations which are not measurable

> nor standardisable. A highly developed sense of responsibility is a self-evident premise. (ibid., author's translation)

Quality control, on the other hand, requires generally accepted medical guidelines (Vetter & Lüscher 1983: 886). The newly set focus on CME, that is, on the acquisition of clinical knowledge, caused critical reactions about the epistemological base of family medicine, and about the relation between knowledge and practice. One author states that quality control that focuses on CME, lays its emphasis on "knowledge" only and ignores "experience" and "intuition". In explaining the necessity of including these additional features, he claims:

> Only experience, a combination of both knowledge and ability, is the ready-made pastry, not the ingredients. Daily work is the best teacher for all physicians; it alone makes him become an experienced physician. […] Can experience be taught, evaluated? (Jakob 1988: 798, author's translation)

Another author (Haase 1988: 15, author's translation) further describes the particular constraints of family medicine with respect to quality assurance: He points out the "specificity" of family medicine, where clientele and the anamnestic and therapeutic procedures are different than those in clinical settings. He stresses the value of the doctor-patient relationship in family medicine and wonders how this aspect of care could be evaluated. Although quality assurance (understood here as CME) enables physicians to keep up with the latest scientific state of the art, Haase (ibid.) adds that CME is organised by clinicians working in hospitals and thus refers to a different clientele and different questions than the ones family physicians are confronted with in their daily practice.[80]

As a reaction to the growing discussion of quality, many authors stressed that proactivism is required to avoid external, politically imposed quality control of medicine (Sahli 1988: 800. 802), and that quality control should thus be institutionalised by physicians themselves (Naef 1981: 3544). They describe quality assurance in health

[80] In 2011 the FMH speciality titles for *general practice* and *internal medicine* were consolidated and renamed as *general internal medicine* (Bauer & Hänggeli 2010), a step which revived debates like those in the late 1980s (s. for instance the letters to the editor in the journal *PrimaryCare* 2010 10(4)).

care as a "postulate of the politicians" which turns medical care into a political football (Haase 1988: 16, author's translation). Therefore, they call for a proactive role for physicians in terms of quality assurance instead of a passive one:

> Let us assure quality among colleagues, before the politicians force us to do so. In this sense quality assurance does not mean more State, more paternalism, more regimentation, least of all the kind that is dictated from "top down" or "from elsewhere". (ibid., author's translation)

To realise this proactive role, it is claimed that the necessity of quality improvement must be incorporated by physicians:

> What shall we do to avoid such restrictions requested by a critical public? Most importantly: We ourselves must recognise and approve the necessity of the introduction of quality assuring activities. (Sahli 1988: 802, author's translation)

In connection with these discussions of quality in the late 1980s, possibilities of sanctioning in case of misconduct were negotiated. Focusing on CME, it was discussed whether physicians were to undergo periodic testing. Accordingly, they would not receive a lifelong permit to practice medicine, but would have to undergo regular evaluations to prove that they were au courant with the latest scientific level (Haase 1988; Jakob 1988). Additionally, it was mentioned that the liability of health insurance companies should depend on the physician's attendance at CME modules (ibid.: 79). Another way to enhance the pressure on physicians to take part in CME programs would be either to pay higher rates to the ones who fulfil these requirements (positive incentives) (Sahli 1989: 17) or to exclude members from cantonal medical associations if they did not fulfil requirements (negative incentives) (Jakob 1988: 799). However, already in these earlier discussions it was noted that mandatory quality programs are "not a guarantee for good medicine" (ibid., author's translation). So, still by the late 1980s there existed no legal claims on quality control, although family physicians themselves had begun to reflect on medical quality in research networks and quality circles, as one reads in the history of *Swisspep*, which represents *EQuiP* in Switzerland.[81] Influenced by the "veritable flood of quality initi-

[81] http://www.swisspep.ch/ueber-uns.html [10.08.2011].

atives covering almost all sectors of industry" since the mid-1980s (Sklair 2001: 116)[82], the 1990s strongly promoted a quality controversy in family medicine which finds its expression in the increasing number of intra-professional articles about medical quality published in Swiss medical journals.[83] The next chapter will thus focus on these more recent developments which started with the revision of the health insurance law in 1996.

To sum up: I have shown in this chapter that the modern quality rationale has travelled globally (from the United States to Switzerland) since the late 1940s. Quality discussions are linked to times of change within health-care systems, such as the large medical-ethical crises, the setting up of national health systems, the economic crises linked to them, and the various re-organisations within these systems (e.g. specialisation, managed care, revision of the Swiss health insurance law in 1996). They are typically driven by critical discussions about professional autonomy and the transformation of medicine into a field of multiple expertise.

Against this background, quality discussions are to be seen as negotiations across professional boundaries in which family medicine struggles to preserve its professional self-positioning and autonomy. None the less, discussions of quality are also about legitimate definitions of medical knowledge, body, health, illness, and patienthood. They thus serve as defining areas for the negotiation of "appropriate" epistemological reference systems. As I have shown, family medicine came to position itself in a very specific way in terms of medical quality. Although current quality discourse employs a rather uniform vocabulary, it is this historically accumulated understanding to which the actors in family medicine refer to, as we will see.

On its journey, modern quality thinking was moved along by various concepts and actors along a broad highway from industry to family medicine. Some family physicians proved to be very receptive to these new ideas, whereas others were rather crit-

[82] An example for this is the publication of *ISO 9000 Series Quality Standards* from 1987 on by the *International Organization for Standardization (ISO)* (Mouradian 2002).

[83] For example Vieli (1995), Egli (1994a, 1995a, 1994b, 1994c, 1995b), Brütsch (1992), Streit (1993), Schmidt (1995), Fröhlich Egli (1995), Peltenburg (1993), Gedeon (1994), Jakob (1995), Gerlach et al. (1995), Künzi (1995) or Langewitz et al. (1992).

ical and hesitant. Despite this ambivalent attitude within the medical fraternity, the importance of pro-activism to avoid governmentally imposed quality programs was stressed. Therefore the participation in quality control was regarded as a way to escape the spectre of external control of family medicine. With this pro-activist attitude, family medicine largely contributed to the establishment, promotion and implementation of modern quality thinking in family medicine.

Based on the historical trajectories of the modern quality rationale, I will now turn to more recent discussions of quality in Swiss family medicine, which began to evolve in 1996. At that time, the revised Swiss health insurance law declared the control of medical quality to be mandatory, and commanded health providers and health insurance companies to co-create quality programs. In this respect I will show how the struggle about definition, measurement, and control of quality created a quality apparatus or, in Foucault's term, a quality *dispositive*.

Doctor Gebhard | Passionate about patients' stories

Dr Gebhard holds a degree in internal medicine. He has a single practice located in a suburban community right between the industry zone of the nearby city and the first farm houses of the surrounding mountain region.

During his years of medical education he worked in the fields of psychiatry, obstetrics, and surgery. He is influenced – as many of his colleagues – by the biopsychosocial approach which the medical professor Rolf Adler adapted to the Swiss context. Dr Gebhard likes to visit upgrade training courses, is member of a monthly Balint group, a weekly quality circle of family doctors and specialists working in the hospital, and a quality circle dealing with ultrasound matters. Additionally, he regularly visits a psychoanalyst if he needs counselling in relation to cases which are psychologically complex.

Dr Gebhard is very interested about his patients' living contexts. He likes complex stories much more than rather simple cases because they make his average working days more interesting. He is convinced that the communication with the patient is an element of the consultation which gains ever more importance. He is fascinated by problems patients suffer from which he is familiar with but which are extraordinary for the patients themselves. He feels ambivalent about home visits because they are time consuming but provide insight into patients' homes.

Dr Gebhard chose to specialise in internal medicine because many symptoms appear uncertain and often have a biopsychosocial dimension which needs to be considered. He worked in a hospital for a while but left due to competition among colleagues.

A larger percentage of Dr Gebhard's patients are asylum seekers. By law they do not have free choice of medical practitioner but are assigned to a certain family doctor. Dr Gebhard treats most asylum seekers from his community because he apparently works cheaper than his colleagues do and is thus the doctor who the municipal administration delegates asylum seekers to. During the last years Dr Gebhard has acquired basic knowledge about his migrant patients' various backgrounds, belief systems, ideas of care and cure, and complex family structures. The children and fathers usually quickly adapt to the local conventions whereas many mothers have only little

contact with the local community and thus lack of German skills. In the consultations they either depend on a child, their husband or a relative who translate for them. Especially issues concerning sexual health are sensitive. Regularly Dr Gebhard is confronted with teenage daughters' desire to get a prescription for the pill and with their request not to tell their parents about it.

When reflecting about his professional future Dr Gebhard expresses his uncertainty to remain in his single practice. He perceives the collaboration with some insurance services as troublesome and is critical about the marketisation of medical services which he illustrates with emerging centres for iron infusions. Additionally, the decline of family doctors leads to an increase of patients per doctor and thus increases Dr Gebhard's workload.

Dr Gebhard is married and has two adult sons. Reflecting on the past years he tells that his priorities used to lie on the organisation of his practice. He regrets to have spent too little time with his family. Back then he was available full time for his patients and felt a strong responsibility for them whereas today he delegates phone calls outside his working hours to colleagues who are on duty.

Doctor Hauser | working as a family doctor in the mountains

Dr Hauser is 56 years old and has a double practice in a popular mountain village with a strong tourism industry. He is a general practitioner with additional degrees in manual medicine, neural therapy, systemic counselling and psychosomatic and psychosocial medicine. He is strongly interested in the margins of biomedicine. Dr Hauser is particularly interested in adjusting medical practice to the living contexts of his patients instead of applying clinical guidelines one to one.

At the age of 42 he had a horrible accident and almost died. He still suffers from some physical handicaps as a result from this accident and the loss of some memories from the years before the accident.

Dr Hauser has a very heterogeneous clientele. He not only treats patients at every age and from every socioeconomic background, but also many tourists and employees from the tourism industry and thus from many different countries. Especially tourists often come without appointment and consider his practice to be a walk-in practice.

After 20 years of working in a double practice Dr Hauser feels ambivalent about this form of practice. On the one hand it is an advantage because of substituting each other during vacation or other absences. Other advantages are the possibility to get couples with complicated relationships treated by two different doctors. On the other hand, however, he and his colleague are also competitors which often refrains them from discussing medical issues with each other. Dr Hauser compares a double practice to a marriage with the same ups and downs across the years.

Dr Hauser is member of a former Balint group which now focuses on systemic analysis and counselling and regularly meets for retreats. He is particularly interested in searching for ways to handle complex interpersonal and emotional issues. He and his local colleagues once tried to establish a quality circle. This project failed due to the workload and time pressure of the quality circle members but also due to their ambivalent feelings towards each other: they were not only colleagues but also competitors.

Dr Hauser is planning to get retired step by step, i.e. by reducing his working load slowly. He still likes to work as a family doctor but also struggles with some developments of the health care system. For instance, Dr Hauser feels very critical about the collaboration of medicine and the industrial research which puts economic interests forward. Additional aspects of medical practice he feels critical about are the increasing information flow and the many kilos of medical journals and advertisement he receives weekly. Furthermore he feels an ever increasing pressure by external performance ratings such as the ones happening on internet rating platforms.

Doctor Isler | Practicing an anthroposophically influenced family medicine

Dr Isler is a 56 years old family doctor who is married and has got four children. Beside her practice she is an active politician on a cantonal level. She holds additional degrees in anthroposophic medicine and in medical education. Dr Isler studied medicine at a time when many medical students wanted to become family doctors and did not think about doing research or becoming a medical professor. Her choice of specialisation in anthroposophic medicine was strongly influenced by her former female chief physician in the hospital where she was a second-year resident. It was someone Dr Isler truly admired.

She started with her practice in 1985, together with her husband. She had grown up in the community where she opened her practice. Actually, she did not want to return to her hometown but her husband fell in love with the place. Step by step they enlarged their practice to a group practice of currently four doctors who all work part time. Dr Isler's husband is also the head of a small department of complementary medicine at the local hospital. At the beginning of their career Dr Isler and her husband were managing an African hospital for two years and got used to collaborating with each other despite their different ways of working. At the weekends she sometimes works in her husband's unit at the hospital. Dr Isler is member of a quality circle consisting of family and hospital doctors and a rare visitor of a Balint group.
Dr Isler has a mixed clientele with a lot of children. She is also working as the school doctor at the local Rudolf Steiner school. Dr Isler considers herself to be a tough and demanding doctor with little patience and empathy for patients who do not express a will to get better.

> We [Gilles Deleuze and François Châtelet, author's note] had no taste for abstractions, Unity, Totality, Reason, Subject. We set ourselves the task of analyzing mixed forms, arrangements, what Foucault called apparatuses. We set out to follow and disentangle lines rather than work back to points: a cartography, involving microanalysis […]. We looked for foci of unification, nodes of totalization, and processes of subjectification in arrangements, and they were always relative, they could always be dismantled in order to follow some restless line still further. We weren't looking for origins, even lost or deleted ones, but setting out to catch things where they were at work, in the middle: breaking things open, breaking words open. We weren't looking for something timeless, not even the timelessness of time, but for new things being formed, the emergence of what Foucault calls "actuality". (Deleuze 1995: 86)

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4 Emergence of a quality dispositive since 1996

4.1 Swiss family medicine and quality requirements between 1996 and 2012

Global discussions on medical quality are led by renowned independent non-profit organisations such as the *Institute of Health Improvement (IHI)* and the *Institute of Medicine (IOM)* in the United States (Kenney 2008). In this respect, the IOM (2001) report *Crossing the quality chasm: a new health system for the 21st century* is a basic publication with a strong influence on the "quality community". The *IOM*'s six improvement aims for the health-care system are *safety*, *effectiveness*, *patient-*

centeredness, timeliness, efficiency, and *equity*.[84] In the European context the *Committee of Ministers of the Council of Europe* (Contencin et al. 2006)[85], *Wonca Europe*'s quality group *EQuiP*, large-scale quality programs such as the British *pay-for-performance* scheme *Quality and Outcome Framework (COF)* or the *EU* evaluation project *Quality and Costs of Primary Care in Europe (COPC)* are shaping the trajectories of reflection and research on quality in family medicine. Despite a general fascination for the ideas and concepts presented in these reports, an interviewed *FMH* representative emphasised that they can hardly ever be implemented in the Swiss health-care system, which she described, due to its federalistic structure, as a "special case". Nevertheless, the quality rhetorics in the Swiss context have adapted strongly to these global quality concepts. The *FMH*, for instance, considers quality of care as treating the patient at the right time, in the right place with the best possible medical effort, in an effective, appropriate, and economic manner.[86] However, starting with these rather standard terms, the *FMH* has gone on to search for an understanding of medical quality which is adapted to the local context. A further *FMH* position paper (Peltenburg et al. 2005) thus worked out a mission statement on medical quality that emphasises the need to conceptualise quality in an all-encompassing way. A physician's commitment to quality thus implies the relieving of suffering, promotion of health, co-productions with other providers and patients, pursuing the principles of evidence-based medicine, a patient-centered way of working (transparently, with no undue strain on the patient), a self-reflective and creatively engaged way of working, and the pursuit of CME, all while taking into due consideration the claims of society, politics, ethics, economics and insurances. Yet, the proposed but not further explained examples of quality outcome indicators (costs of healing, degree of handicap,

[84] Available online at http://www.ihi.org/IHI/About/VisionValues/ [06.02.2011].

[85] In 1997 the committee urged for „the need to define policies and set up structures for quality improvement at all levels of healthcare, including individual providers and practices in ambulatory care". Four years later it recommended to realise quality programs that rely on medical guidelines and CME (Contencin et al. 2006: 65).

[86] *FMH* position papers, available online at
http://www.fmh.ch/files/pdf1/2009_03_11_positionspapier_qualitaet_d1.pdf and
http://www.fmh.ch/files/pdf4/Positionspapier_Zweckmaessigkeit_D.pdf [06.02.2011].

quality of dying, re-gained or lost quality of life, or the ability to work) (ibid.: 1057) illustrate how difficult is the implementation of such broad concepts.

In Switzerland the revised health insurance law that went into force in 1996 marks a culmination point in discussions of medical quality. This revision stipulated a re-structuring of the Swiss health-care system, to re-establish solidarity as a basic principle[87] and to lower the costs of health-care services.[88] Cost-containment was meant to be achieved by the implementation of new payment models (e.g. the national tariff system *Tarmed* or lump-sum payments[89]), new insurance models (e.g. *HMO*), and quality assurance.[90] In this respect, quality assurance was defined as a legal regulation (art. 56 and 58), yet without being further specified. The federal promotion of quality improvement and the setting-up of a national quality control program were thus regarded as answers to a perceived need: the decrease of health-care costs. Health providers and health insurance companies were obliged to co-create and implement quality concepts until 2012. Health providers were asked to elaborate propositions and to present them to the health insurance companies. So, on the one hand the Swiss state began to interfere in medical quality matters, i.e. in something that previously was dealt with intra-professionally: Before 1996 quality discussions took

[87] The revised law obliges every citizen to have a basic health insurance contract. Health insurance companies, on the other hand, are obliged to accept every applicant into the basic health insurance model. This is based on the idea of solidarity, so that health insurance companies do not accept so called "good risks" only, meaning only patients who are young, male and healthy and presumably carried at low-cost by the companies. Additionally, premium rates were levelled across client categories, so that the elderly and sick, for example, do not have to pay higher premiums than the young and healthy (Widmer & Wolffers 1996: 13f; Kuhn 1995: 2012). However, the practice of hunting for good risks moved to the additional insurance model, in which not every patient must be accepted and in which every patient pays a fee according to his risk-structure (Widmer & Wolffers 1996: 20). For a discussion of the contemporary understanding of risk and the risk rationality of private insurances, s. Schmidt-Semisch (2004: 223). For an analysis of Swiss health insurance companies' risk-selection practices, s. Baumgartner & Busato (2012).

[88] For an overview of the overall implications which this revision has brought to pass, s. for example Widmer & Wolffers (1996), Kuhn (1995) or Brunner (1995).

[89] Examples here are the reimbursement of doctors or institutions according to diagnosis-related groups (DRGs) instead of single-services units, or the strongly debated introduction of a monthly salary for doctors in independent practices.

[90] Markus Moser, in his presentation *Das neue KVG und seine praktische Umsetzung* held at the *University of Zurich* on 9 November 1995, during the course of an interdisciplinary series of lectures titled *Das neue KVG – Was ändert sich im Gesundheitswesen?*.

place within the medical professions (s. section 3.3), whereas thereafter it became an extra-professional and thus public issue. On the other hand, however, the realisation of this claim implied a partial pull-back of the State (cp. Lemke 2000: 11), because health providers (medical associations and medical fraternities) and health insurance companies were delegated to co-create quality concepts themselves.

In contrast to industrial sectors, where quality initiatives often proved to be very successful, the State-sponsored effort at instituting quality programs in medicine took an undesirable turn. Instead of initiating common quality programs, health providers and health insurance companies failed to reach agreement. At this point I would like to present notes taken during an interview with the head of the *FMH* department *Data, Demography, Quality (DDQ)*[91]: Driven by the federal request and their own approach of defining quality as a co-production among different actors (Peltenburg et al. 2005), the *FMH* made several attempts to realise quality activities with *Santésuisse*, the head association of all Swiss health insurance companies. However, these attempts have proven to be difficult because the two actors have diverging ideas of what quality is, and how it should be made visible. My interview partner told me that the *FMH* follows the strategy of "making transparent" the quality activities of physicians, whereas this descriptive level is not enough for *Santésuisse* representatives. They claim for the development of indicators that would allow to measure "outcome quality". With these measures they aim at benchmarking physicians and approach and sanction those who do not perform according the defined quality targets (Santésuisse 2008). The *FMH*, on the other hand, aims at protecting its members from such benchmarks and thus refuses to give up data sovereignty. In this stuck situation quality programs coordinated by both health providers of the ambulatory sector and health insurers were hardly realised, as I was told. This delay was unintentionally encouraged by the governmental preoccupation with developing quality programs in health institutions (e.g. hospitals and nursing homes) first. Although in other countries with a strong primary care sector "quality mechanisms are often more extensively developed in primary care than in hospital settings" (Mäkelä et al. 2001:

[91] *German* Daten, Demographie, Qualität (DDQ).

32f), this is notably not the case in Switzerland. The controversial quality understandings and the associated interests of the respective actors described above were certainly further complicated by the federal structure of the Swiss health-care system. This impasse led to action by the *Federal Office of Public Health (FOPH)*, which was forced to re-intervene in 2009 and take the lead in planning a national quality program (Bundesamt für Gesundheit BAG 2009). Moved by this intervention, the *FMH* finally launched "Q-Monitoring" and "Q-Initiative", two large-scale, centralised quality programs in ambulatory care originally conceptualised as a common project between *FMH* and *Santésuisse*.[92]

The national quality strategy which was launched by the *FOPH* in 2011 is the latest attempt to co-create a large-scale quality program with various representatives from the health care sector. Because even those quality programs coordinated by the health insurance companies and the medical associations have proven to be difficult to implement, the feasibility of an even larger cooperation with an annual budget of 20-25 million Swiss francs (Bundesamt für Gesundheit BAG 2011: 24f) seems, therefore, almost utopian. The long road to achieving its goals is suggested by the fact that in the 58-page conceptual paper the terms "quality" and "qualitative" are mentioned 502 times without being defined concretely.[93]

Despite the inclusion of quality control in the revised health insurance law, the majority of family physicians whom I encountered during my fieldwork paid little attention to the discussions of quality I have mentioned above. This can be explained in part by the fact that a mandatory system of quality control does not yet exist. One doctor, an active member in CME programs, explained that he will maintain a passive attitude until a mandatory quality program is implemented. He said that so far he only fulfils mandatory quality requirements such as laboratory assessments, CME, or quality-circle meetings. The evaluation of patient satisfaction, for example, or the

[92] "Q-Monitoring" collects data on quality assurance by submitting questionnaires based on quality-related information from the medical fraternities. "Q-Initiative" collects all activities that doctors consider as "quality activities".

[93] The authors of this report refer to the revised health insurance law of 1996 where quality is not defined either but presented as a given term.

quality certification of his practice through institutes offering evaluation services, are things that he postpones until they become mandatory:

> Such a questionnaire campaign would cost around 3‘000 [Swiss] francs. I don’t need to be afraid if the national government wants to conduct this in my practice and distributes questionnaires. But [I’m] not [willing to do this] if I have to do the work myself and even pay for it myself. Only to tick off the quality category “patient satisfaction”, and not only “continuous medical education”, with an „achieved“. There is a nice saying: „Don’t march faster than the band plays“. Certainly not „pushing“. (Dr Jakob)

The reluctance formulated here stands in diametrical opposition to the proactive strategies that medical representatives have formulated in various articles since the 1980s. In these statements, the intra-professional establishment of quality assurance is represented as a necessity to forestall the imposition of the extra-professional regulation of medicine according to external forms of quality control.

4.2 Theoretical framing: emergence of a quality dispositive

In view of all this, I consider the federal request for transparency and quality control in medicine to be a “discursive event” (Foucault 1974: 16, author’s translation; Link 1997; Bublitz 2001; Schwab-Trapp 2001), followed by a liminal phase in which this request should be realised. When the State pulled out, as happened in 1996 after the federal claim for quality control mandated health providers and health insurers to develop quality programs, a re-organisation of technologies in governance emerged (Lemke 2000: 11). This event marks a moment of disruption, discontinuity and transformation (Schochow 2010: 223): 1996 challenged professional boundaries, competences and autonomies by transforming medical quality from an intra-professional to an extra-professional and thus multidisciplinary matter. As a consequence, there gradually emerged a quality network consisting of laws, interest groups, research projects, publications, conferences, evaluation and certification procedures, concepts and strategies, specific rhetorics, and quality “experts”. Both Giorgio Agamben and Michel Foucault’s definitions of an *apparatus* frame the nature of this network.

Agamben (2009: 12) defines an apparatus as "[…] a set of practices, bodies of knowledge, measures, and institutions that aim to manage, govern, control, and orient – in a way that purports to be useful – the behaviours, gestures, and thoughts of human beings". Additionally, Foucault's definition points out that the emergence of an apparatus – or *dispositive* as he also calls it – does not happen at random but in specific historical contexts:

> What I'm trying to single out with this term is, first and foremost, a thoroughly heterogeneous set consisting of discourses, institutions, architectural forms, regulatory decisions, laws, administrative measures, scientific statements, philosophical, moral, and philanthropic propositions – in short, the said as much as the unsaid. Such are the elements of the apparatus. The apparatus itself is the network that can be established between these elements […]. […] by the term "apparatus" I mean a kind of formation, so to speak, that at a given historical moment has as its major function the response to an urgency. The apparatus therefore has a dominant strategic function […]. (Foucault in a 1977 interview, in Agamben 2009: 2)

Dispositives put their main focus on the interplay between power and knowledge, analysing "a set of strategies of the relations of forces supporting, and supported by, certain types of knowledge" (ibid.). In the quality dispositive, this relation between power and knowledge is exercised through the negotiation of the definition, measurement, and control of medical quality. That is, how it is defined depends on the conceptualisations of health, illness, body, and patienthood and builds on a specific type of knowledge production. The definitions and conceptualisations chosen are momentous, because the definition of quality and a specific operationalisation thereof eventually determine the ways in which medical performance can be controlled and finally sanctioned.

In the Swiss quality dispositive there is not one single locus of control or power, meaning for instance that there is no top-down regulation which determines medical practice. The quality dispositive is in fact to be imagined as an interplay of both repressive and productive mechanisms (Foucault 2005: 76), ranging on a continuum

between externally regulating *technologies of power*[94] and *technologies of the self*[95] (Lemke 2000: 37). Although quality improvement is often described as a „recent, and resisted, phenomenon" (Mäkelä et al. 2001: 31), to conceptualise it as a politically implemented regime imposed on family medicine – which is how I perceived quality discussions in the early stage of my research – would miss the point completely. Reflecting on the trajectories of power in a quite different context, Foucault (2005: 79) noted that "power is not localised in the State apparatus" but rather "outside, below and alongside the State apparatuses, on a much more minute and everyday level".[96] The regulatory power of the quality dispositive is thus not limited to top-down regulations, such as the above-mentioned health insurance law, but can be described as a democratised control technology (Bublitz 2010: 155).

4.2.1 Discourse, discursivation: more talking and less meaning

The quality dispositive is, in my understanding, penetrated by discourses on key quality concepts such as *cost-effectiveness*, *evidence*, *efficacy*, *patient-centeredness*, and *patient safety* which negotiate the boundaries of professional space. The term *discourse* applied in this thesis refers to a poststructuralist, Foucaultian perspective that understands language, in short, as "embedded in social and political settings and used for certain purposes" (Lupton 1994: 20). "A discourse", so Deborah Lupton (ibid.) continues, is "a pattern of words, figures of speech, concepts, values and symbols. […] Discourses gather around an object, person, social group or event of interest, providing a means of 'making sense' of that object, person, and so on […]". In this respect it is stressed that discourses are initiated by a specific discursive event that is both conflictual and public (Schwab-Trapp 2001). Despite the different positions in the quality dispositive, there emerged a standardised quality rhetoric, a quality argumentarium circling around a set of concepts such as the ones named above. Quality discourses are thus governed by a specific terminological body which repre-

[94] Technologies of power "determine the conduct of individuals and submit them to certain ends or domination, an objectivizing of the subject" (Foucault 1988: 18).

[95] Among these technologies of the self are for instance quality circles, Balint groups, demonstrations of the medical fraternity, family medicine's quality rhetorics, the *FMH* quality projects, or family physicians offering practice evaluations and certifications.

[96] Translation found at http://www.generation-online.org/p/fpfoucault6.htm [30.03.2012].

sents one of their central modalities (cp. Schwab-Trapp 2001: 262). Consequently, within the quality dispositive the different actors use the same quality terminology and therefore act as if quality were a collective (global) symbol. Yet, they have developed competing readings of these concepts such that meanings, interpretations, reference systems, underlying paradigms and the interests behind this increasingly standardised terminology vary greatly and thus create a specific discursive formation (ibid.: 267). Davies & Harré formulated the relationship between position and perspective accurately:

> Once having taken up a particular position as one's own, a person inevitably sees the world from the vantage point of that position and in terms of the particular images, metaphors, story lines and concepts which are made relevant within the particular discursive practice in which they are positioned. (Davies & Harré 1990: 46)

An additional aspect of these different readings is the open character of many quality concepts (e.g. patient-centeredness, chapter 6), meaning that they can be understood as well as operationalised in different ways. Especially in terms of these open concepts, it is at times difficult to grasp the actors' understanding of them. Usually, these understandings do not become evident at first glance but – apart from conducting fieldwork on this issue – only when being operationalised in the course of developing items and indicators used for quality measurement. The operationalisation of quality concepts is thus one way to learn about the meanings and definitions attached to them, but also about the specific understandings of health, illness, body, and patienthood on which the quality definitions are based. Yet very often they also illustrate the limits of translating broad and multi-layered quality concepts into measurable categories.

Consequently, these open concepts render quality discussions complicated – from the perspective of the involved actors as well as from a researcher's perspective – because the same terminology pertains to many different meanings. So, instead of facilitating discussions through a common language, as concepts are supposed to do (Bal 2009: 22f), a different case holds here. This simultaneity of both unification (common terminology) and fragmentation (different meanings and realisation strategies)

is a typical characteristic for globally circulating phenomena (Held 1992: 32). As the logical consequence of this discrepancy between quality terminology and its diverging meanings, there are hardly any contact points between the different actors involved in these quality discussions. This disconnection finds expression both in the drawbacks of quality cooperations between different actor groups and in the difficulty of defining and agreeing on quality outcome measures.

Concepts such as evidence, on the other hand, are less open but tied to a specific epistemological reference system and a certain type of knowledge production (s. chapter 6). In this respect, certain types of knowledge are considered superior to and thus more valid than others, a view expressed in (originally industrial) notions such as "best practice" and "gold standard" (Sklair 2001: 41). Sklair (ibid.: 140) analyses such notions "as a technique of social, political, and ideological control". From a governmentality perspective they may thus be considered as governing tools, "aiming to shape, guide or affect the conduct of some person or persons" as Gordon (1991: 2) generally remarks about governance. These concepts thus form a "rationality of government" which Gordon (ibid.: 3) defines as „a way or system of thinking about the nature of the practice of government (who can govern; what governing is; what or who is governed), capable of making some form of that activity thinkable and practicable both to its practitioners and to those upon whom it was practised". Against this background, government is to be thought of as a discursive field where the rationality of power works through the establishment of regulatory terms, concepts, the definition of objects and boundaries, and through the provision of arguments and rationales. In this respect, government represents a form of problematisation that defines a political-epistemological space (Lemke 2000). Thereby, the repetition of terms and of lines of arguments forms a central mechanism of the dispositive. This can be observed in discussions of medical quality which have increased enormously in the last years: Quality remains a major term in health care discussions, to such an extent that I would identify the category of *rhetorical quality activism*: Currently, there is almost no official statement about health care topics that does not include the quality notion. In their book on transparency, Stehr & Wallner (2010: 13, author's translation) stress that political communication is increasingly about the

wrapping instead of the content, a displacement that results in a "flattening of the discourse" in which "details and background remain increasingly omitted". In this respect, quality is sometimes used as a buzzword, sometimes as a filler word, sometimes as a metaphor and only very rarely in the extensive sense of a concept. So, throughout its journey quality not only travels but also transforms itself along a continuum between word and concept, and "casually walks back and forth between semantics and intention" (Bal 2009: 19). Quality has truly become an inflationary, ordinary, and often imprecisely used term:

> The most confusing ones are the overarching concepts we tend to use, as if their meanings were as clear-cut and common as those of any word in any given language. Depending on the background in which the analyst was initially trained and the cultural genre to which the object belongs, each analysis tends to take for granted a certain use of concepts. Others may not agree with that use, or may even perceive it as not being specific enough to merit arguing about. Such confusion tends to increase with those concepts that are close to ordinary language. (ibid.: 21)

This proliferation of the quality notion has blurred it, inasmuch as it is neither specific nor precise but stands for everything and nothing at the same time. Or in Bal's sense, it has moved from a concept to a label and thus loses its "working force" (Bal 2009: 19, Bal 2002: 23). It is through diffusion that quality has turned into a meaningless label, a process that Bal describes as follows:

> "Diffusion" is the result of an unwarranted and casual "application" of concepts. Application, in this case, entails using concepts as labels that neither explain nor specify, but only name. Such labelling goes on when a concept emerges as fashionable, without the search for new meaning that ought to accompany its development taking place. […] . […] the dilution deprives the concept of its conceptualizing force: of its capacity to distinguish and thereby to make understandable in its specificity; hence, to "theorize" the object, which would thus further knowledge, insight, and understanding. (Bal 2002: 33)

In accordance with Bal's theoretical reflections (ibid.: 26), I argue that the ordinary and non-reflective use of the quality notion in health care leads to misunderstandings, controversies and disputes. Its fuzzy, programmatic and highly political character precludes its use as an analytical tool. Or, as Donabedian (1980: 20) noted, "[t]here is

the danger of enlarging the definition of quality so much that it loses distinctiveness and analytic utility, becoming almost a slogan which means nearly anything anyone chooses it to mean". None the less, it is exactly this fuzzy character of the quality notion that also turns it into an adequate rhetorical instrument in negotiations among positions and proper interests.

4.2.2 Technologies of the self

Apart from the regulation through enhanced discursivation, the quality regime is performed through an additional, crucial channel, namely, the "process[es] of subjectification" (Agamben 2009: 11) to which individual actors and institutions submit. The emergence of a quality dispositive requires that actors, or more precisely family physicians are convinced that quality is genuinely at issue, that it is important and generally enhancing to both profits and well-being, that there are ways to achieve it, and that there is a need to control and manage it. Such processes finally result in so called "technologies of the self" [97] that Foucault (1988: 18) described as practices that "permit individuals to effect by their own means or with the help of others a certain number of operations on their own bodies and souls, thoughts, conduct, and way of being, so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection, or immortality". Government is thus to be imagined as an interaction of "technologies of power" and ""technologies of the self" (ibid.). This implies that techniques of the self are not simply an effect of domination but also that the two techniques interact (Burchell 1996: 21). In this sense, "techniques of the self are integrated into structures of coercion" (ibid.: 20 citing Foucault 1980).

Before 1996, "care for the self" (Gordon 1991: 44) was an intra-professional matter: It was formulated in medical ethics codes or took place in informal groups, quality circles, Balint groups, in personal processes of self-reflection, CME, voluntarily conducted practice evaluations, conferences, and the like. The well-known terms *self-*

[97] Several reformulations of *technologies of the self* exist, such as *techniques of the self* and *self-conduct* (e.g. Burchell 1996), *care for the self* (e.g. Gordon 1991) and *practices of the self* (e.g. Lupton 1996).

reflection, *self-evaluation*, *self-improvement*, and *self-management*[98] illustrate the mechanisms of the quality regime through technologies of the self, and are already mentioned in early quality discussions of family medicine:

> In the betterment of our community, self-help is the best kind of help. It is the hope of the Trust that Dr. Taylor's report may provide a reliable and stimulating manual for those engaged in the front line of the battle against ill health. (Farrer-Brown in his foreword in Taylor 1954: xix)

> And while striving to achieve these [quality] ends he [the physician] must remember that, though he is never capable of perfection, he always has the ability of self-improvement. (Jeffs 1973: 690)

> „Quality" is not a static or fully measurable standard, and should probably be viewed as a constant *process* of improvement requiring continued self-assessment. (Geyman 1976: 133, emphasis in original)

The goal of 1996 was, however, to externalise the care for the self and make it transparent, measurable, improvable and thus controllable. With the claim of transparency and quality control, the care for the self is thus required to take place in a specific, "valid" sense. One doctor remarks:

> Now, whether we want to or not, we are compared with a commodity. And we ourselves cannot weigh it [quality] anymore […]. This spoils my joy. (Dr Odermatt)

Yet, as another doctor noted, quality discourses – even when perceived as detached from daily practice – have had an impact on family physicians' quality perception and stimulated processes of self-reflection about what quality means to them:

> Under the notion „quality", physicians have been forced to communicate with each other about its meaning. Before, each of us has simply worked it out for himself. To me this [change] is positive. (Dr Tanner)

So, the quality regime constructs subjects who are only supposedly free but who find themselves, in fact, in a field of tension between autonomy and regulation (Lemke 2000: 41). One of the rationales applied to promote care for the self is an „imperative

[98] S. for example Baarts et al. (2000), Hitzler & Pfadenhauer (1999) or Bolton (2010).

of responsibility“ (Giri 2000) owed to society (Lemke 2000: 10f). In this sense, care of the self contributes to the „preservation, reproduction and reconstruction of one's own *human capital*“ (Gordon 1991: 44, emphasis in original) which is necessary for a functioning system. Care of the self is thus directed "against the (wrong) manner of how we govern our self" (Lemke 2000: 11, author's translation). Consequently, the individual constantly must go through processes of regulating discipline and morale (ibid.: 14) which correspond to the notions "betterment of man" (Mouradian 2002: 85), „behaviour change“ (Donabedian 2003: 27) or "continuous improvement" (ibid.: xxviii). From this perspective, actors are treated as if they were businesses, as projects that constantly need to be reflected and worked on (Gershon 2011: 539). They constantly need to be "invested in, nurtured, managed, and developed" (Martin 2000: 582 in Gershon 2011: 539) and thus improved. In this respect, actors are seen as "individual entrepreneurs" (Gershon 2011: 540) whose continuous self-reflexivity and self-management leads to success (ibid.: 542). Thus, from a neoliberal perspective, the self "is composed of usable traits" and "marketable capacities" that he/she "brings to relationships" (ibid.: 539):

> The worker provides a skill set that can be enhanced according to the employer's requirements – part of what is being offered is the worker's reflexive ability to be an improvable subject. (ibid.: 540)

To ensure that individuals adhere to these requirements, these individuals must constantly be "evaluated, judged, and disciplined" (Lemke 2000: 11, author's translation). Such processes are not necessarily incorporated smoothly, for they imply „counter-conducts“, „strategic reversibility“, or „resistance“ (Gordon 1991: 5). In the case of medical quality, these different forms of conduct are accompanied by conflicts and negotiations within the group of actors that undergo these processes. For instance, a family physician working in a touristic mountain village said that he sees public discussions about medical quality as remote from his daily practice and individual horizon of experience:

> […] the objective [of these quality statements] is totally different. One can define any numbers. One can say that a hypertonic patient may have a blood pressure value that is not above 0. The HbA1c [glycosylated haemoglobin] of a dia-

> betic patient may not be like this and like this, and so on. One can of course define this in numbers. But if one limits oneself to that… If one looks at it on a purely technocratic level it comes to its limits because these people don't function like a laboratory rat. (Dr Hauser)

Other physicians emphasised that quality discussions are led by actors who are detached from medical practice. Quality discussions are thus considered as too isolated and removed from daily practice. Family physicians stressed that they have a different agenda and a different logic in defining and measuring quality. As one doctor (Dr Quinn) says, quality discussions are linked to ideas and terms that are "alien" to family medicine. As a consequence of such types of perception, many family physicians feel excluded from public quality discussions. Even a doctor in an HMO group practice, where quality management is given great attention, told me that "quality decisions are made without physicians" (Dr Meier).

4.2.3 Quality as transit point for discourses within the dispositive

Interestingly, despite family physicians' hesitation, restraint, lack of knowledge, and general feeling of detachment about public quality discussions, the strategy implicit in their associations and organisations does not distance them from the quality notion. In fact, they address quality performatively and strategically in various ways. In this respect, they use quality as an instrument for positioning family medicine in the transforming health care system. It is part of a larger strategy that was established during the last several years, one that is characterised by presenting family medicine as a non-dispensable, scientific, cost-effective, and highly qualitative medical specialty. Remarkably, the term "general practice" has increasingly disappeared from public discussions and has been replaced by "family medicine"[99]. The pushing of this notion seems to be programmatic and thus part of a larger strategy of strengthening the primary-care disciplines. This is illustrated by the foundation of *Family doctors of Switzerland*[100], a professional association for family physicians and pediatricians[101], or a political initiative called *Vote yes for family medicine* (s. section 1.3). I

[99] *German* Hausarztmedizin.
[100] *German* Hausärzte Schweiz.
[101] S. footnote 13.

gather that proponents prefer the notion family medicine over, for instance, general practice because they wish to stress that family medicine is a medical specialty in its own right. The term general practice, of course, does not express that. The logo that was created for the new initiative (figure 2) illustrates how these disciplines place their focus on patients' heterogeneity: this is their specialty and their "quality".

Figure 2: Logo of initiative *Vote yes for family medicine*

This larger strategy implies a broad staging of family medicine, including:

- *The "going public" of family medicine* through media presence, demonstrations, advertisement, or political initiatives, media reports, films, fiction, and theatre productions.
- *The establishment of larger professional networks* and working groups.
- *The academisation of family medicine* by founding university departments, organizing scientific conferences and establishing research projects conducted by family physicians.

These strategic elements are intertwined, as shown in the case of an international meeting held in Basel in 2009, the *Wonca* regional conference. Being regularly updated about the planning and organising process, I got to have a look behind the curtain. The *Wonca* regional conference was very meaningful for Swiss family medicine – both professionally and politically. It was used not only as a form of CME but, further, as a way of staging family medicine via its forms of knowledge and knowledge production. The choice of the conference topic – *The Fascination of Complexity. Dealing with Individuals in a Field of Uncertainty* – was no accident, but a strategic and political move to re-think practice, theory and knowledge (production) in family medicine. The conference was part of a series of actions undertaken to promote and strengthen family medicine in Switzerland, such as the formation of the association *Family doctors of Switzerland* during the course of the conference, and its launching of the political initiative *Vote yes for family medicine* a few months

later. In all the amalgamations, presentations and publications which are part of this strategy, the quality notion was applied.

The inflationary use of the quality notion mentioned above exemplifies what Foucault meant by productive forms of power: the modern quality regime is not only established through repressive forces such as laws, prohibitions or sanctions, but also through the constant use, through increased discursivation and proliferation of the quality notion, as well as through incentives such as promises (better health, better health outcomes, best practice, decrease of costs, increased efficiency, etc.). Quality is thus something that is constantly being talked, written, and researched about. Repeated over and over again in an inflationary way, it has turned into a "discursive automatism" (Conradi 2010: 231, author's translation). The power of this automatisation is enhanced by the global journey of the modern quality rationale that I referred to in chapter 3.

Due to its air of being unquestionable, quality represents an extremely useful rhetorical device: Of course, everyone agrees with the necessity of quality, and everyone agrees that quality exists in some way or another. These reflections have recently been reworked in the context of health. In 2010 Jonathan M. Metzl & Anna Kirkland (2010) published a book called *Against health. How health became the new morality*. The introduction starts with the questions "How can anyone take a stand against health? What could be wrong with health? Shouldn't we be *for* health?" (Metzl 2010: 1, emphasis in original). Metzl (ibid.: 2) argues that health is not only a "desired state" but beyond that "a prescribed state and an ideological position". He emphasises that the term health "is used to make moral judgements, convey prejudice, sell product" and much more (ibid.). Metzl (ibid.: 4) shows how health is used as a substitutional term for critical terms such as "moralism" or "capitalism", to name only a few. In their book the authors thus aim at deconstructing and unravelling health, "and to explore the ideologies, structures, base pairs, and blind assumptions involved in its construction" (ibid.: 4f). Metzl (ibid.: 5, emphasis in original) refers to the work of medical sociologists, for example Talcott Parsons, who considered "health as a *normativizing rhetoric*", or Foucault, whose approach conceptualises

health as a regulatory concept, "as a *discourse of power*, a discourse that is productive rather than repressive".

Transferring these thoughts to the quality dispositive, one sees a series of analytical questions arise: Why is the quality notion applied in such a proliferated and imprecise way if it is a label rather than a concept? What do actors intend to reach if they debate with the help of the quality notion? Which positions, claims, and interests stand behind the application of this term? At this point I argue that the quality notion is strategically applied as a euphemism for specific interests and their attendant negotiations and legitimisations (Allan & Burridge 1991). In this sense, the quality notion is thus a way to enforce something, to emphasise its importance and trustworthiness. Thus, it represents a specific rhetorical device and argumentation strategy applied to achieve and legitimate political agendas, professional interests and positions. Hence, similar to Foucault's (1998: 103) analytical reflections on sexuality which he considered as a "transfer point" for specific power relations, quality can be conceptualised as another such transfer point through which different discourses move and aim at taking effect. In the chapters to follow I will analyse the position of family medicine in some of the main discourses that penetrate the quality dispositive. They are about economisation, evidence, patient centeredness, and patient safety.

Doctor Jakob | Being moved by the particularities of his patients' stories

Dr Jakob has worked as a family doctor in a large city for 21 years. He has a double practice (HMO) with a female colleague which is part of a large physician network. His consultation room reminds of ancient times because he likes to collect antiques from medical cabinets and pharmacies. Dr Jakob lives 200 meters from his practice. After he completed his medical education, he was offered both a rural as well as an urban practice. Due to his experiences from substituting for a colleague for a period of eight months and from his working experience abroad (Africa and South America), he was afraid that he would have an exceptional position in the village which he did not want at all. Working as an urban doctor enables him to better separate between medical practice and private life. Today, Dr Jakob's clientele is heterogeneous which he is fond of: he does not want to become a specialist for a particular group of patients or for a certain type of diseases.

Dr Jakob tells that the closer he comes to retirement the more he loses his idealism and the conviction that he carries full responsibility for his patients. Today, he considers himself largely as a triager. However, all his patients who are severely ill have his cell phone number and can reach him at any time. He also stresses that even after having practiced medicine for many years he has not lost his genuine interest for his patients, for where they come from, who they are, and how one generation differs from the next. Many of them have come to see him for many years. In some cases, he is the doctor of three generations within one family. The continuity of care in family medicine is his motivation to work in the ambulant setting rather than in a hospital. Even though the field of medicine develops continuously, he considers most of the symptoms as a "déjà-vu". Not so with his patients: every story has its particularities and surprises.

Dr Jakob used to be a member of a Balint group for a couple of years and is still a member of a quality circle of family doctors and pharmacists who are all working in the same part of the city. He also works part time for a health insurance company in the field of risk evaluation, meaning that he evaluates requests from patients who apply for the additional insurance model and decides if they can be accepted or not.

Additionally, he works as a lecturer at the university's medical department and as a school doctor in a college. Furthermore, he regularly visits and organises upgrade training courses and medical conferences.

Doctor Kuhn | Specialised in migration and health

Dr Kuhn is in his late fifties, divorced and father of two adult daughters. The double practice of him and his colleague, who are both specialised in internal medicine, is located in an urban university district and exists for thirteen years. It is part of a physician network. Dr Kuhn first had a double practice with a female colleague. Together they were medically responsible for migrants staying temporary in a centre. After he left the centre and the practice to establish a new double practice with more space available, he kept many of these patients and their families. Many of them live in social and economic precarious conditions and share traumatic migration stories, experiences with torture, homesickness and integration problems. Dr Kuhn works part-time in a center for victims of torture where – apart from individual counselling – he and his colleagues also organise upgrade training courses for colleagues who wish to learn more about migration and health. Currently, around a third of Dr Kuhn's patients have a migration background, whereas his colleague is specialised in – mostly elderly – patients suffering from diabetes. Dr Kuhn is truly interested in his patients' heterogenic biographies, in their characters, and appreciates the fact that he accompanies many of his patients for many years. As a third part-time job, Dr Kuhn works as a medical examiner for a health insurance company.

Dr Kuhn notes a certain tendency of decrease in professional collaboration, meaning that he feels excluded from treatment processes as soon as a patient enters a hospital treatment. Nevertheless, he stresses that a professional network is an indispensable criteria of his work. That is why for many years Dr Kuhn has been participating in three different quality circles (one with doctors and pharmacists from the same district, one with colleagues who all care for patients from homes for elderly, and one which is associated to the physicians network), a Balint group, an intervision group and is an active member of an interdisciplinary group of researchers in the field of medical anthropology. In these groups he learns about varying perspectives on specific cases, concerns and topics.

Doctor Lehner | From patients to wine bottles

Dr Lehner considers himself as an unconventional family doctor and paediatrician who never stayed in one place and always felt to be ahead of the times with his ideas and activities. Through the collaboration with colleagues from countries with an elaborated primary health care system he soon learnt about approaches such as progressive teaching methods (e.g. problem based learning), innovative practice models (e.g. HMO and regular group practices), quality improvement, large scale monitoring systems and clinical research in family medicine. He tried to establish these approaches in Switzerland. Throughout his career he felt passionate about research and published his results in high ranking journals. But he always felt to overstrain his Swiss colleagues with his progressive approaches. After extended research activities in other European countries and working in extra-European countries such as Nigeria, Papua New Guinea and Jamaica he established his first practice in Switzerland at the age of 43 years. His wife not only accompanied him to the various destinations abroad but also successfully worked as his medical practice assistant.

After his retirement Dr Lehner and his wife moved to Southern France where they started with winegrowing. Several times per year he comes back to Switzerland to substitute for his colleagues' practices what he describes as his "third career". When talking about the current Swiss health care system and the primary health care setting Dr Lehner feels ambivalent and critical. He emphasises that the system is rather conservative and implements structures and models which have been implemented in other Western health care systems 25 years ago.

> The rule of efficiency governs the lived time of the patient-practitioner encounter. Regulations control practice, transforming the doctor into the "provider" of a "product" that is advertised, marketed, and sold. Care is commoditized. Even the lived space of practices is standardized to conform to the institution's blueprint for functionality. The technical rationality of the institution, its priorities and norms, shape biomedicine. The physician is bureaucrat; the patient is a user, a consumer of the institution's services. The very imagery of care constructs an industrial logic to its delivery and evaluation, reducing the moral space of the career of illness and of the work of doctoring to a minimum. (Kleinman 1995: 37)

5 The economisation of family medicine

> I think that we have a budget to manage, and also a certain energy along with it. Money, which is available from the health insurance companies but also from private actors. Managing this money well, working in an economical manner [is what defines a good family physician]. (Dr Aeschbacher)
>
> One is a good physician when one manages to solve the problems of the patient with reasonable means, […] without producing too many costs. In a reasonable time with reasonable effort. (Dr Notter)

As these opening quotations show, economic responsibility constitutes an inherent aspect of physicians' work and their notions of what it means to be a good physician. This intertwining of economic reasoning with demands for medical quality is embedded in a global discursive process called *economisation*[102]. It emerged in the

[102] Löffler (2003: 22) lists several synonyms used for economisation such as "marketisation", "managerialism", or "new public management".

1980s and was diffused throughout many sectors of society, such as the welfare and health-care systems (Harms & Reichard 2003: 13). Löffler (2003: 19) describes discourses on economisation as a "global trend" that increased with the turn from the 20th to the 21st centuries. Harms & Reichard (2003: 13, author's translation) explain that in the course of economisation, performance was increasingly oriented towards „economic categories, values and principles". They attribute this trend to the *neoliberal turn* and its strong focus on market forces and competition instead of a welfare state (ibid.: 14). In this respect economisation serves as a notion for different yet similarly proceeding developments which have in common a main focus on economic scarcity (Löffler 2003: 23) and cost containment (Burchell 1996: 27). As a consequence, governments have depended increasingly on an "increase of economic efficiency" and additional incomes (Löffler 2003: 15, author's translation). These neoliberal forces turned "most spheres of social life into businesses, by making social institutions – such as schools, universities, prisons, hospitals, welfare systems – more business-like" (Sklair 2001: 114). As a consequence of this „global redescription of the social in the name of the economic", as Gordon (1991: 43) writes, "anthropological categories and frameworks of the human and social sciences" were pushed away (s. also Maio 2011). In this sense, all professional relationships are regarded as "market alliances" and "business partnership[s]" (Gershon 2011: 540). Business rationality is applied as a "pervasive style of conduct, diffusing the enterprise-form throughout the social fabric as its generalized principle of functioning" (Gordon 1991: 42). In this respect, "neoliberal agency emerges as conscious choices that balance alliances, responsibility, and risk using a means-ends calculus" (Gershon 2011: 540). Against this background, various writers emphasise that economic crises usually intensify discussions of transparency (Stehr & Wallner 2010: 15), because quality-improvement programs such as TQM are regarded as a way out (Martin 1994: 211).

The *economisation of medicine* refers to a paradigm shift in Western medicine, particularly legitimised by the increase of health-care costs. Among the reasons for this increase were demographic aspects (e.g. increased life expectancy and thus increased long-term-care dependency), and high costs of medication and professional services, as Rychner (2006: 49) lists them in the Swiss context. Rising health-care costs as

well as the critical discussions on the status of the professions were a fertile ground for re-thinking medicine from new perspectives, that is, mainly from economic and management points of view. It was the onset of a "permanent political and scientific dispute as to which reforms are the right reforms" (Kälble 2005: 3). With reforms, "the medical profession should be forced and urged to act in a more cost and quality-conscious manner and to utilize existing resources in the most efficient way possible" (ibid.: 7). Kälble (ibid.) continues by summarizing that physicians are "required to be more result-oriented, more efficient, and more economically profitable, without neglecting the quality of care and attention given to patients". In referring to the North-American context, Arthur Kleinman stressed:

> Regulation via bureaucratic rationality, state control, and the "market" is remaking biomedicine in North America, for example, into an institution that has more in common with many of the other agencies of government and business bureaucracies than it does with healing systems in other societies or with the biomedicine that existed even a quarter of a century ago. (Kleinman 1995: 39)

Market models with their emphasis on self-regulation through competition are considered as the way to reduce these health costs (Rychner 2006: 59) and at the same time guarantee "better quality" (ibid.: 60, author's translation). Rychner (ibid.: 56, author's translation) concludes that these new models can be regarded as symbols "for the not yet realised Better".

(Economic) efficiency is a key concept, or more precisely, one of the discourses that runs through the quality dispositive. The intertwining of economic questions with ideas of medical quality is by no means an effect of the neoliberal turn alone, but has also formed an integral part of the modern quality rationale from early on (Donabedian 2003: 17). In fact, as I have shown in chapter 3, quality discussions in medicine came into existence mainly when economic situations took a bad turn (e.g. cost explosion after the war, set up of health systems). However, in contrast to these earlier episodes, neoliberal "cost-containment policies" have had a fundamental impact on professional boundaries and autonomies (Kälble 2005: 6). The economisation of medicine implied a re-conceptualisation of the health-care sector including its structures, institutions and actors groups:

> [Neoliberal] Government must work for the game of market competition and as a kind of enterprise itself, and new quasi-entrepreneurial and market models of action or practical systems must be invented for the conduct of individuals, groups and institutions within those areas of life hitherto seen as being either outside of or even antagonistic to the economic. (Burchell 1996: 27)

Therefore, with the neoliberal turn, market and "enterprise" rationality (ibid.) was implemented in fields such as medicine (Rylko-Bauer & Farmer 2002; Coiera & Braithwaite 2009; Eisenring 2004; Bauman 2003; Stier 2009; Rychner 2006), where until then actors such as the medical fraternities were eager to draw a line between care and profit.[103] As a consequence, quality control was not only considered an economic necessity but was increasingly conceptualised and operationalised in a quantified way. Economisation discourses thus introduced a new quality notion and thus changed medical quality into something measurable, controllable, and convertible into outcomes and economic values. In addition, the cost-effectiveness rationale assumes a causal relation between physicians' quality, better health outcomes and reduced costs.

In the course of these developments, different cost-containment strategies and policies were implemented, or were attempted, to raise professionals' awareness of the costs they produce. Examples of this are the tariff system Tarmed, managed-care and HMO practices, or the implementation of DRGs which re-structured processes of treatment in terms of a "fragmentation of patient processes into (economically) defined parts" (Berchtold 2007: 317, author's translation). These strategies materially embody the economisation of medicine, and are presented as instruments of quality control in this chapter. The negotiations about these cost-containment strategies represent "disputes between medicine and the economy regarding who is allowed to do the interpreting and defining in the public health system" (Kälble 2005: 8). They have resulted in heated debates over the spheres of competence, traditions, and iden-

[103] Stein (1998: 95) states that "for many physicians, medicine is a business that cannot be acknowledged to be a business. This conflict between giving medical care and receiving some form of remuneration had been silenced long before 'marketing' and 'advertising' were introduced into medical organizations. There have long been barriers to discussing publicly whether biomedicine should be a business like all other businesses".

tities of the medical professions (s. for example Li 1996; Stein 1998). The medical historian Paul Unschuld (2009: 74) considers these new structures to be barriers to professional autonomy, and also a rationalisation of medicine that has resulted in a deep crisis of what care and treatment are all about. However, as I will show later in this chapter, the economisation of medicine also creates new professional models and new spaces of agency. It is thus by no means generally rejected by family physicians.

Against this background, it is interesting to focus on the ways in which these economising forces have altered medical practice and its key concepts of health, illness, doctor, patient, and knowledge. Kleinman (1995: 33), for instance, states that "generalizability, quantification, prediction, efficiency, quality control" are "virtues […] attributed to bureaucratic rationality" which have then become part of "the professional structure of biomedicine". Physicians, Kleinman (ibid.: 39) criticises, passively accept "a patient-doctor relationship that is just another instance of consumer-client interactions characteristic of a market economy". Yet, other scholars have shown that physicians by no means accept this change passively. Many physicians struggle with the explicit prioritization of economy over medicine (Kälble 2005: 8; Unschuld 2009: 70), which builds on a cost-benefit rationale to evaluate consultations (Kälble 2005: 7f). Some react with harsh criticism and rejection, whereas others acquire the necessary skills to adapt to these new structures or apply strategies to continue with their style of caring even under management structures (Stein 1998: 9).

5.1 Tariffs versus the meaning of time

In 2004 Tarmed[104], a tariff system for services in ambulatory Swiss medicine, was introduced. When I started my fieldwork in 2005, it was still something very new and unfamiliar to the physicians I talked to. In the years to follow I observed how the members of the quality circle which I attended on a monthly basis became more and

[104] Derived from the French term „tarif médical".

more familiar with this system, how they accumulated specific knowledge and skills, and how a great deal of this happened through exchanging Tarmed experiences and strategies within the group. Yet, for many physicians this new way of billing their services, namely through fragmentation of their consultations into a set of different categories, and through temporal structuring of these categories, also created struggle and frustration in daily practice. The idea of Tarmed and its consequences for medical performance represents one concrete example of the abstract and popular notion of the "economisation of medicine". (Post-festum reflection, 14 November 2011)

Economic reflections are a mandatory aspect of physicians' daily work. The implementation of the tariff system Tarmed has forced physicians to learn about the costs they and their patients produce. Tarmed consists of 4'500 different positions that can be assigned to a medical act. The sum of the applied positions corresponds to the amount of money physicians receive for their services. Tarmed thus aims both at raising economic awareness among physicians and at controlling their services. A physician told me that she perceives this tariff regulation of her work as restrictive:

> […] I'm not allowed to bill more than 30 minutes, meaning that I'm not allowed to talk more than 30 minutes with a person who is in a severe crisis. These are the restrictions that are difficult to bear. […] This is the dark side [of our job]. It's the Government's influence on our procedures. It's a system which is very restrictive. (Dr Quinn)

Tarmed can be considered as an "economic guideline" (Kälble 2005: 2) for physicians that is based on the idea that a medical consultation can be divided and categorised into single temporal bits that can each be translated into a tariff position.[105] The sum of these single positions represents the whole consultation and thus the whole amount of money the doctor will receive for his service. Things like technical developments or changing working conditions should lead to a regular revision of the whole tariff system's structure, as the health insurance law says (art. 43 para. 4). Yet,

[105] All the information on Tarmed in this paragraph stems from http://www.admin.ch/ch/d/ff/2011/7385.pdf [27.10.2011], a parliamentary report released on 1 September 2011.

the health insurance companies and the medical associations have not managed to reach a consensus, so that only individual tariff positions were adapted but not the system as a whole. As a consequence, the *FOPH* was forced to intervene, as in the case of quality control.

The translation of the content of consultation into a set of tariff positions represents one of the major challenges for many family physicians. It seems to be difficult to divide medical consultations into clear-cut temporal fragments, because they consist of various bits that are hard to line up[106] if only because they are intertwined and overlapping. One doctor explained this as follows:

> You talk crisscross, once it's medical advice, the next sentence is an instruction, followed by mental support. (Dr Escher)

Almost none of the physicians I have talked to works with a timer. So, the structuring of the consultation is most often done "by rule of thumb" (Dr Escher). Due to the fact that only those positions can be listed that refer to the service for the patient (either in his physical presence or absence), activities such as additional medical inquiries, further education, or breaks are not paid for. Physicians thus complain that the sum of the Tarmed positions very often does not correspond to the actual time spent at work. Additionally, there occur many situations in medical practice which cannot be assigned clearly to one position, or definitions of a position change. Concerning the latter one doctor criticises:

> If someone has a foreign particle in his forearm, and the branch canal is diagonal, the excision of the foreign particle is measured in centimeters by means of the distance from the foreign particle to the skin. […] Superficial injuries cost less than injuries under the skin. People have found out that these calculations are hard to make and have created a new definition: the branch canal is not the decisive factor but rather the distance between foreign particle and skin, measured at a right angle. That is Tarmed. (Dr Escher)

Ironically, then, for many physicians this tariff-based work is time consuming and increases the workload. For this reason, physicians search for strategies to overcome

[106] For an attempt at this, s. Litschgi & Schlumpf (2012).

these perceived constraints. For instance, the fact that some services can be assigned to different positions results in family physicians' comparisons with respect to the "best", i.e. the highest-paying tariff. During these discussions it is evident that some physicians have invested time in earning as much money as in pre-Tarmed times, whereas others earn less than before. One doctor expressed her lack of understanding about the second type of colleague:

> [Their decreased income] is partly concerned with naivety, partly with constraints, partly with the ambition to be correct, partly because they are afraid of *Santésuisse* […]. (Dr Ruch)

Restricting and structuring the duration of medical consultations is one way in which the economisation of medicine takes place. Tarmed in this respect is used as an instrument to regulate medical practice based on a specific, monochronic understanding of time. In the context of managed care, which I will discuss more thoroughly in section 5.3, Stein (1998: 83) states that it "is one expression of a culture-wide redefinition of the way time is to be structured and experienced. The only thing that matters is the production line and the immediate short-term profit gained from it". This understanding of time is different from "the real-time nature of social phenomena" (Strathern 2000a: 318). Family physicians, for instance, have a broad, polychronic relationship to time, as Dombeck et al. note:

> There's more and more financial pressures and the insurers have little interest to do effective medicine, they want fast and superficial help which costs less, they believe!! These facts lead up to consequences that psychosomatic medicine done by internists [is] considered expensive because we spend more time with patients. There is still a lot of work to do until the insurers realize that this same time spent with patients pays off. (Dombeck et al. 2003: 241)

Spending time with the patient in the consulting room, creating an open space for illness narratives, leaving the patient time to deal with his illness or to make a decision about further treatment, and awaiting a diagnosis: These and many more examples express an additional perception and handling of time than the one required by

the tariff system.[107] Time in this respect is understood as a resource of care (Cassell 1984: 53). Physicians emphasise that it is not only a requirement for diagnostic work but, beyond that, also an expectation of patients. That is why to be short of time[108] often conflicts with family physicians' perceptions of good medicine (Dr Notter).

In medical practice the discrepancy between temporal requirements formulated by Tarmed and the situations in consulting rooms is handled in different ways. Interview partners explained that a good doctor needs to be able to distinguish between symptoms that can be treated rapidly (e.g., sore throat), emergencies that call for immediate action, and issues that take longer. They try to adapt their performance to these heterogeneous conditions. Two physicians recount:

> I see myself as a down-to-earth doctor. I try to make the split between being a quickly working doctor – who I must be, it's our reality that we have to rush our patients to a certain extent. On the other hand I've got people […] who I see three times for a conversation in which we get very close. (Dr Aeschbacher)

> In medical practice it's often the case that one likes to observe certain symptoms without making an immediate intervention. They are evaluated on the basis of one's own clinical experience. This knowledge allows me to judge if a certain case is an emergency, if it's dangerous, or if one can wait. In terms of the latter, one has to decide whether to wait for two months, two weeks, or two days. Often, these are decisions where one cannot rely on guidelines. (Dr Escher)

Another doctor schedules 30 instead of 15 minutes per consultation, and works strictly according to a clock on her table. If she is not done with a patient after 30 minutes, the patient will come back for a second consultation. She emphasises, however, that in general the time spent per patient is less than 30 minutes, leaving „freedom" and time for either a „phone call, a report, a referral" or an emergency patient (Dr Quinn). To her this is an aspect of quality related to sound planning. Additionally, she tries to assist patients in learning how to interpret and treat symptoms themselves:

[107] For an anthropological analysis of different perceptions of time, s. for example Hall (1983) or Levine (1997).
[108] Doctors listed manifold reasons for the delay of consultations, reaching from poor planning to too many inscribed patients to factors having to do with patient-doctor communication.

> I try to teach people to react independently in cases of emergency: How can I help myself first before I run to the phone? What might I suffer from? What is reasonable? And do I have a drug in stock? Concerning often recurring symptoms, I write a [reserve] prescription. A reserve drug for often recurring symptoms. Among women infections of the bladder are a typical example: Like this [with the prescription], they needn't come to the clinic for an old problem that keeps resulting in an infection. Instead, they've got some antibiotics at home. I try to plan this in advance. Of course not everything can be planned. […] I would certainly consider it a quality feature that […] the patients get educated. […] Here, patients' demands for little things that could have really waited for two days was very high in the last two years. (Dr Quinn)

Yet another doctor told me that he asks some of his patients to list their questions before the consultation and to bring that list along. In that way he can limit the frame of the consultation better and thus try to prevent the consultation from escalating. However, I also have heard about time-management strategies that indicate certain difficulties in practising medicine in a satisfying way when time is short. One doctor admitted:

> In my practice I've got a schedule. If two patients show up without appointments I refer them much more often to someone else.
>
> *To other family physicians or to specialists?*
>
> To specialists, because I know that the other family physicians are also too busy. If I've got 15 minutes available where I actually would need half an hour – illustrating this on stomach ache – I certainly make a sonography for 350 [Swiss] francs and a laboratory test. If you're short on time you can examine less exactly. If I've got time to really listen to the stomach…. Of course I'm careful not to refer every non-scheduled patient, but it happens automatically. There are studies that show that under time pressure a lot more laboratory tests are conducted. Then I've got the test results in writing which provides security. I try my best to do it differently but at times patients wait for 45 minutes. This is terrible! If I'm 45 minutes late and someone who is not scheduled shows up with something small that could be treated within two minutes… With some patients it [the treatment] would last two minutes, yet with others I know that I won't manage to win their trust within two minutes for my two-minute-diagnosis. I tell them to make a blood count. Then they continue the consultation with my medical practice assistant. With these laboratory tests and sonographies you know that you haven't missed anything. We have very few dangerous cases. However, for a consultation you need a certain calm, time, and also experience. For the experi-

> ence, in turn, I need time, time to examine well, time to ask good questions. I need half an hour for an anamnesis. With the examination added, this makes 45 minutes. So if you're under pressure but still aim at doing a good job, you refer more often and conduct more laboratory tests. (Dr Aeschbacher)

This last quotation shows how the temporal requirements implemented by economizing processes may not produce more cost-efficient treatments in every case, but rather result in redirections of treatment. In the context of temporal requirements and physicians' perceived shortness of time for consultations, Astin et al. (2006: 564) note that "the current health care delivery system may, in many respects, be antithetical to the biopsychosocial model". In his attempt to shed light on the rationing of time, Loewy lists physicians' tasks during a consultation, encompassing anamnesis and physical examination, "diagnosis, prognosis, and options of treatment", the promotion of patients' health literacy and critical thinking, the inclusion of the patient's personal background in a patient-centered manner, the filling out of "a prescription or a referral slip", and record keeping of the consultation and the decisions made. "And, by the way", as Loewy (2005: 452) concludes cynically, "you have fifteen minutes in which to do this".

5.2 Family physicians and health insurance companies

Temporal and economic guidelines systems such as Tarmed represent fields of tension and conflict between family physicians and health insurance companies. A doctor who strongly supports the claims for transparency explains her feeling of ambiguity as follows:

> I have always argued for transparency. I supported Tarmed even though I shouldn't speak out loud now. I share the idea of paying attention to the time required [for a service], to write it down and to manage it well. Now I'm terribly disappointed that it doesn't work better with Tarmed. Over a certain period I have billed way too little money with Tarmed. It really wouldn't work anymore [economically speaking]. In addition the medical practice assistant changed. I often worked in the evenings, studied the case records or made some phone calls. On a lot of bills I wrote the tariff position „work in the absence of the patient", which costs 14.90 [Swiss] francs per five minutes. Thereupon the health

> insurance companies called me, which really hurt me. They just don't control the right things. It hurt me that I had to justify why on 2 December 2005 I billed five minutes „work in absence of the patient" for an elderly woman, and on 16 December again. With this woman I manage a huge story because she confuses her pills. This is related to the discussion about generics. Mix-ups happen if an elderly patient, who has my medication plan, all of a sudden receives generics from the pharmacist. Of course I support generics, and I prescribe the cheaper therapy in the first place. […] Let's take diabetes as an example: I can prescribe a new drug from the outset which costs three [Swiss] francs a day. Or I can prescribe the old drug which costs one franc per day and which works equally well. If I prescribe the old drug, I receive a request from the health insurance companies about my reasons for not having prescribed the generics for this old drug. If I had prescribed the new drug which is three times more expensive no one would have asked because there are no generics for it. That annoys me. […]
>
> *Do these queries happen often?*
>
> Yes, that's often the case. But you know, I'm among those [physicians] who call out for the health insurance companies' queries. I simply felt hurt because they inquire about such stupid things. But I can tell you why they did so. Last year they were happy with me because I billed less than the average [of physicians does]. Then they measured the change. Before, my volume of sales was a quarter less, now it has increased plus a quarter. Yet if someone consistently earns too much money it's no problem. (Dr Aeschbacher)

In his reflection on such critical enquiries made by health insurance companies, Loewy (2005: 460) remarks that "[c]are has always been managed: medical colleges, licensure, chart review committees, CME requirements, and the various ways in which physicians are monitored in and out of the hospital have assured that physicians meet certain criteria of training and practice in acceptable ways. That is not the kind of management we have in mind. Managed care today is mainly about saving money and not about practicing good medicine".

In Switzerland, citizens are required by law to be insured by one of the existing health insurance companies. As a consequence, the health insurance companies are obliged to pay a greater part of the medical treatment costs. In receiving the bills, they see what they are to be paying for, and legally they have the competence to decide whether or not they will pay the bill. It is not exceptional for there to be disagreements between health insurance companies and physicians about adequate care.

As my interview partners told me, the health insurance companies usually refer to a specific list of evidence-based guidelines concerning treatment. Although it is commonly stressed that deviating from the guidelines does not lead to negative sanctions (Baumberger 2005: 176), family physicians perceive it differently: If they deviate from the guidelines they usually risk being asked to justify their alternative trajectories of medical decision-making and treatment to the health insurance companies. In some cases these inquiries may go back several years. One of my interview partners comments on these enquiries as follows:

> […] one has to justify [the prescription of] incontinence diapers, physiotherapies, and drug prescriptions again and again.
>
> *Why incontinence diapers?*
>
> That's the latest gag. Yesterday a patient called me who wears these diapers day and night which costs 900 [Swiss] francs a month. They are great: they are absorptive, you don't smell anything but they are expensive too, such as Pampers®. It's annoying that I have to justify them. I mean, nobody wears these diapers voluntarily. She suffers from an incontinence degree 4 and I have to fill in a whole questionnaire about "why" and "what", and if it wouldn't work with fewer diapers. This is the homework that awaits us at the end of the day. (Dr Jakob)

It is very much this type of justification (Why has one treated a patient longer? Why has one treated a patient in a different way?) that family physicians fear when reflecting on future quality measurements. Family physicians perceive these inquiries as inadequate, disturbing and time-consuming. Yet, what they really fear are cost-effectiveness proceedings[109] opened against them by the health insurance companies. The health insurance companies base these proceedings on articles 32 and 56 in the revised health insurance law, which defines services to be "effective, appropriate and economic" (KVG art. 32, par. 1, author's translation) to be reimbursed by the health insurance companies (Santésuisse 2009). Cost-effectiveness proceedings can be opened if a doctor generates annual costs that surmount the benchmark calculated by the health insurance companies by 30% or more (Romanens et al. 2009). With these benchmarks, health insurance companies aim at fighting against over-supply (ibid.: 52). In cases where the insurance companies succeed in winning a case against a

[109] *German* Wirtschaftlichkeitsprüfungen.

specific doctor, the doctor is forced to pay back a large sum of money. The above cited doctor continues his reflections on this topic:

> Each of us finds himself in a glasshouse, we are „rated" and „ranked". […] If my average [of produced costs] is too high, they approach me. Or if I prescribe too many drugs […] I may eventually have to pay back money. These cost-effectiveness proceedings are thus common. They are something very, very severe for the persons concerned. Of course, black sheep exist but... Two close friends of mine have experienced it [proceeding]. It stretches over one and a half years, and during that time you're in the dock. […] We physicians are screwed. (Dr Jakob)

Physicians complain that these proceedings do not take into consideration that family physicians, despite their broad focus of general practice, very often have a certain type of patients. The characteristics of this clientele might depend on the doctor him- or herself (specialisation, age, gender, personality etc.), but also on the location of his or her practice (deprived area, university district etc.), and they vary in terms of different morbidities, treatment, and medication. A doctor with whom I worked closely with mainly treats elderly patients suffering from multimorbidities. In a long interview, another doctor emphasised that her clientele mainly consists of drug addicted HIV/Aids patients whose treatment is very expensive. She is thus likely to face a cost-effectiveness proceeding in the near future that would mark the end of her medical career:

> I'm not willing to make many more compromises. It's directed against something very personal: my basic attitude towards my job. If I have to work in an environment that doesn't suit me anymore, I'd rather quit. (Dr Quinn)

Santésuisse is accused of having a narrow understanding of cost-effectiveness proceedings (Romanens et al. 2009: 49). The criticism is that *Santésuisse* calculates the cost effectiveness of a physician's services based on data that do not account for morbidity variables. Critics thus accuse *Santésuisse* of an evaluation process that is not transparent, not validated and unquestioned, which lacks of diagnostic precision (ibid.: 52), focuses only on overly expensive physicians but not on underpriced ones, and evaluates economic consequences instead of medical issues (Schlossberg 2008).

Not least due to these proceedings, family physicians are very reluctant to have data related to their services published, such as prescription statistics. They have their own "trust centres"[110] where their data is stored and evaluated. These trust centers consider themselves to be the linking point between physicians and health insurance companies, because they store the physicians' bills in a database from which the insurance companies can draw upon the minimum of information they need to transact the payback to their insured clients. Additionally, these trust centres use data from physicians to create statistics and benchmarks that are then sent as feedback to the physicians. In the purview of this situation, the single physicians receive statistical information about their treatment and billing behaviours and have the possibility to compare themselves with a certain collective of physicians. It thus serves them as a tool for self-evaluation and benchmarking, yet on an optional basis and without any consequences attached. Upon physicians' approval, these data can be used further for large-scale comparisons and analyses.

In physicians' narrative accounts about their clouded relationships with the health insurance companies, those companies are represented as an anonymous and hostile block. Health insurance companies are to a large extent described as actors that complicate medical practice and sometimes even hinder treatments that the physicians consider as the most adequate ones. In light of the dualistic pictures drawn, the roles of those physicians working part-time in a practice and part-time for a health insurance company are of particular interest. Since the revision of the health insurance law in 1996, health insurance companies are obliged by law (KVG art. 57) to employ physicians (usually from general practice or internal medicine) whose medical expertise is needed to translate, advise, and mediate between patient, the doctor treating him or her, and the health insurance company responsible for the meeting of the costs (Egger 2007: 3). Or more precisely: It is their duty to be attentive to oversupply or unjustified services (ibid.: 51). In an informal talk, one such doctor (Dr Kuhn) told me that it is sometimes difficult to combine these two different settings in

[110] The following information about trust centers stems from the website of *PonteNova*, the trust center in the Canton of Bern (www.pontenova.ch, [22.09.2011]) as well as from a telephone conversation I had with the secretary of *Ponte Nova* on 23 September 2011.

which he works. He specified that critics very often forget that health insurance companies are forced to implement decisions made by the *FOPH*. In his master thesis, the sociologist Jan Egger (2007) has focused on this group of physicians who work for health insurance companies and analysed their position between professional, market and bureaucratic rationalities. He emphasises that health insurance companies have a paradoxical role: On the one hand, these firms are implementing governmental regulations: The *FOPH* regulates the mandatory payments of health insurance companies to the patients based on clearly defined compendia (ibid.: 29) which still leave a certain scope for case-specific decisions (ibid.: 52). Medical examiners control their colleagues' performances and decide on inclusion- and exclusion criteria for services that are to be reimbursed by the insurance company (ibid.: 53). On the other hand, the same firms are enterprises that have to deal with market principles and business competition (ibid.: 28). Accordingly, the above-mentioned doctor perceives his dual position as both a representative of the insurance company and as a doctor to be very difficult and indeed a burden.[111] He thus finds himself in a "schizoid situation" (ibid.: 28). His colleague (Dr Jakob) who also works part-time for an insurance company told me that he could not work in the field of "services" but instead works in the field of "risks": Here, he decides on patients' applications for supplementary insurance. In this field, physicians are not stuck between health insurance companies, patients, and colleagues, but "only" between patients and insurance companies. However, new practice forms – insurance-owned HMO practices orientated towards *managed care* – have produced additional working environments in which physicians work for insurance companies. As the following section on managed care illustrates, these new settings are accompanied by a similar intra-professional scepticism as the one described above.

[111] S. for instance Hoff (1999) for doctors' perceptions of colleagues working in the field of administration.

5.3 Managed care

To enter an HMO group practice is different from entering a regular practice. It is mainly the size that impresses the visitor. The size, together with the presence of many people working there or visiting, creates a feeling of anonymity. In one of the visited practices this was enhanced by the "corporate design" of the practice, consisting of standard furniture, neutral pictures hanging on the walls, the white coats of the physicians (in the other practices I visited, the white coat was usually worn selectively for specific purposes or only in the presence of certain patients), and a single type of tea cup printed with the logo of the practice. Sitting in the waiting room and waiting for my interview appointment with a female doctor (Dr Peters), I felt as if I were observing the busy work in a beehive. Through the glass wall separating the waiting room from the rest of the practice I could observe how patients entered and left, how physicians appeared to call their patients from the waiting room, and how the medical practice assistants' desk acted as the centre of all these activities taking place, virtually coordinating them. As I learnt in one of the interviews with an HMO physician, it is especially the older generation of both physicians and patients who have trouble with the plurality of medical practice assistants and with the large size of the practice.

The members of the quality circle I closely worked with were rather critical about these large HMO practices. This found expression in the sceptical stance towards two members who decided to give up their single practice and instead be employed in an HMO practice. With this transfer the physicians left the quality circle because every HMO practice has its own quality circle. In the remaining meetings before their leave, I experienced several situations where they were confronted with critical questions from the other members of the circle. It goes without saying that I visited this large HMO practice with these critical voices in mind. I was very surprised when the two HMO physicians I interviewed independently of each other told me that they have never worked as freely and calmly as in these highly structured settings. The HMO practice that another interviewed doctor (Dr Debrunner) works in is owned by a health insurance company, whereas Dr Peters's HMO practice be-

longs to a network of physicians and is thus insurance-independent. (Fieldnotes, 23 May 2010)

Managed care serves as an umbrella term for different neoliberal developments and structures of health care, all of which aim at rendering health-care systems better, more efficient, and less expensive. The decrease of costs and the increase of quality through efficient processes of care are thus the aims and legitimising arguments of managed care (Baumberger 2005; Kälble 2005; Huber & Hess 2007). In order to maintain a certain level of quality in these economisation processes, quality is assessed and thus controlled (Kälble 2005: 7). In this respect the various actors who support managed care stress that it eventually leads to "improvement of quality and efficiency",[112] "a better medicine", and "best practice"[113] (author's translations). Thus, the argument of increased quality due to managed care is applied over and over again as an instrument of persuasion and legitimisation for this new model.

The managed care movement emerged in the United States in the 1980s (Scott et al. 2000). Managed care, as the term indicates, combines two different rationalities – management and medicine – which are to guide medical decision-making and treatment (Stein 1998: 80). Rylko-Bauer & Farmer precisely:

> Managed care introduced explicit rationing: by limiting unnecessary use of services (determined by evidence-based guidelines), efficiency in the delivery of care is maximised, patients are better off, and money is saved – so the argument goes. Both patients and physicians are managed through cost-containment techniques that put strict controls on use of medical services and on patients' choice of doctors and medical options and that offer financial incentives to doctors and hospitals to cut costs and services. (Rylko-Bauer & Farmer 2002: 478)

In Switzerland, the first HMO practice, i.e. the first group practice organised in the sense of managed care and owned by an insurance company, emerged in 1990 as the first one in Europe (Baumberger 2005: 173). Today, various Swiss insurance com-

[112] http://www.bag.admin.ch/themen/krankenversicherung/00305/06506/06664/index.html?lang=de [18.05.2012].
[113] http://www.fmc.ch/bessere-medizin [13.10.2011].

panies offer HMO models to their "clients".[114] Physicians employed in these practices receive a monthly salary and have an annual budget for the treatment of their patients (s. section 5.3.1). HMO representatives thus emphasise that the employed physicians do not have an economic temptation that would risk an over-supply (Huber & Hess 2007: 75).

As alternative practice models, there are similarly organised yet insurance-independent and physician-owned HMO networks, such as for example *MediX Switzerland* which has existed since 1998. They have emerged as a response from physicians to HMO practices belonging to insurance companies, with the aim of coordinating patients' treatment routes across institutions and disciplines, and including physicians in sharing economic responsibility. These practices concluded capitation contracts with a group of health insurance companies. Since 1999, *MediX* group practices have been joined by independently working physicians who together form the *MediX practice net*, an open corporation in which they can become shareholders (Huber & Hess 2007: 77f). In these practices organised as capitation models, the open corporation meets all the costs generated by their patients. That is why the shareholders of the practice have „a direct economic incentive to practice cost-saving and qualitatively outstanding medicine" (ibid.: 79, author's translation). Due to the shareholder structure, fields of work not directly linked to the medical encounter, such as referrals or quality circle meetings, can be reimbursed (ibid.). So, physicians working in such a system have an overall entrepreneurial responsibility linked to economic profit sharing. They are, so Huber & Hess (ibid.) argue, more committed to improving work procedures.

The revised Swiss health insurance law of 1996 explicitly allowed the introduction of "health maintenance schemes" such as HMO practices (Uhlmann & Braun 2001: 79). Proponents such as Huber & Hess (2007: 74) consider managed care as a system that targets three problem fields of the Swiss health-care system, which they define

[114] This new rationality transformed the health-care vocabulary completely (Bauman 2003: 194; Stier 2009; Rychner 2006): patients are now considered "consumers", doctors "providers", care is to be "managed", "rationalised" and "optimised", and "efficiency" and "effectiveness" are key terms.

as follows: First, single-service fees[115] lead to over-supply. Second, treatments of patients with complex health problems do not proceed in a coordinated way, which may result in double-treatment or a missing exchange of information among physicians. And third, the heterogeneity of both physicians' services and patients' needs leads to interregional differences which the authors consider as unjust. Despite such pro-managed care voices, the broad establishment of managed care has remained chiefly an ideal of policy makers. Despite some stimulation, such as lower premiums for patients who choose this insurance model, the HMO practice form has not made a breakthrough among Swiss users of health insurance. One of my interview partners (Dr Lehner) considers managed care as an "excellent system", but is convinced of its incompatibility with the Swiss system due to two missing requirements. He explained that Swiss family medicine first needs to be organised in a homogenous way. If some practices follow managed care principles whereas others do not, the managed care system does not work. Additionally, patients need to be trained in considering the family physician as their first recourse in case of a health problem. Against this background, policy makers attempt to transform the ambulatory health-care sector into a large managed care structure. By the end of September 2011, the managed care bill was accepted by the Swiss parliament. None the less, a group of physician organisations (first the *Swiss college of surgeons*, shortly after supported by the *FMH*) decided on going for a referendum, because they are critical of issues regulated by the bill, such as the budget responsibility of physicians or the restriction of free choice of physicians. In their referendum text,[116] they state that the managed care bill is to be opposed because it leads to the loss of free choice, to managed care as a legal compulsion, to a market distortion, and to a loss in quality. However, the association *Family doctors of Switzerland* who at that time had their own political initiative under way (s. section 1.3), did not pursue a referendum but instead supported the bill. In their press release[117] they stated that the bill supports their own claims to a large

[115] *German* Einzelleistungsvergütung.
[116] *FMH* press communiqué from 30.09.2011, online at http://fmch.ch/download/unterschriftenbogen_de_biel_web.pdf [24.10.2011].
[117] http://www.hausaerzteschweiz.ch/uploads/media/Medienmitteilung-MC-DV11-DEF-dt.pdf [03.11.2011].

extent and does include features their medical associations consider important, such as morbidity-based balance of risks,[118] independence of physician networks, as well as the maintenance of obligation to contract. So whether Swiss citizens will vote for or against the inclusion of the managed care bill in the health-insurance law on 17 June 2012, the medical fraternities will not represent professional unity but division instead. Although the medical supporters as well as opponents of the managed-care bill both use an argument built on a quality rhetoric, the impression remains that these debates are instead about the positions of the medical fraternities in the transforming health-care system.

5.3.1 Budget responsibility

Each HMO practice receives an annual budget, which must cover all patients' costs, including treatment by external physicians and institutions. These capitation models have led to the fear that patients' treatment is determined by the practice's efforts to save on outlays (Huber & Hess 2007: 73f). A family physician and at that time leader of an urban, insurance-owned HMO group practice, disagrees with these concerns on under-supply, and explains:

> Of course that's the basic fear and the reproach of all other physicians. I have never experienced this [under-supply]. You can't do it anyway with a single case. What's rather at issue is that patients suppose that you do it that way. I find it difficult if I tell someone to wait until the next day – a form of medicine that I have always practiced – and the patient thinks that I don't want to prescribe him anything. This [patients' fear] might happen. […] But it's clearly article 1 of our practice not to deprive anyone of treatment and not to save costs in such a way. Because, if you look at it from a systems perspective, it always comes back like a boomerang. If you refrain from something today, it will come back to you later, and then perhaps even worse […] because we'll have to pay the whole [sum]. We must try to manage it [budget] in an optimal way, similar to the physicians in the other practices. That's probably not so different. Yet, we have to pay for it [treatment] until the very end. That's why this [detention] is not an issue, on the contrary. The only thing that "budget responsibility" implies is to have a close look at the spending of the money and at those points where something systematic could be changed. An example for that is the field of obstetrics which […]

[118] Instead of only gender- and age-based balances of risks, s. Huber& Hess (2007: 71).

> must be covered by our HMO budget, of course. It represents about one third of our budget which we can do absolutely nothing against. […] These are such mamoth costs… In light of this it doesn't make much of a difference if you prescribe generics instead of an original drug. (Dr Debrunner)

This testimony shows that managed care apparently risks affecting the trust between doctor and patient, and that patients suspect their physicians of changing their styles of treatment in accord with economic restrictions.[119] Huber & Hess (2007) stress that all health-care models (from single services fees to capitation models) are at risk of providing either too much or too little care. To maintain patients' trust in their physicians, they consider "transparency" in medical decisions as fundamental (ibid.: 74, author's translation).

Interestingly, the above quoted doctor emphasises that the idea of the physicians' budget responsibility has proven to be unfeasible in his practice, for several reasons. He explained that many additional costs beyond those actually produced in consultations have been loaded onto this budget responsibility. Among them are the high costs of quality improvement efforts. As a consequence, this specific (insurance-owned) HMO practice has long been in the red. The doctor stated:

> To be honest, the health insurance companies are also concerned about something else [and thus accept the negative budgets]: They clearly want an entry for good risks. They invite the HMO [model] to transfer them [good risks to the additional insurance]. (Dr Debrunner)[120]

This fishing for healthy and thus cheaper patients (s. also Rychner 2006: 51) is one reason why physicians with an expensive clientele, such as for instance HIV/Aids patients, are virtually forced to abandon their patients when taking up work in an HMO practice (Dr Quinn).

Due to their budget responsibility, HMO practices are interested in referring their patients to physicians from within the HMO network and in this sense act as "tri-

[119] For the relation between managed care and trust, s. also Li (1996: 917) and Rylko & Farmer (2002).

[120] For an empirical study of Swiss insurance companies' attraction and selection of "good risks", s. Baumgartner & Busato (2012).

ageurs" and "gatekeepers" (Baumberger 2005: 175). In HMO practices, the idea of the "gatekeeping" system is established in different fields and expressed through a rigorous division of labour among employees in the practice. On the one hand, there is a strict division of labour among the medical practice assistants, between the medical practice assistants and the physicians, between the different physicians, and lastly between the physicians and their network of specialists, including practice nurses, osteopaths, and the like. The medical practice assistants are responsible for the entire administrative workload related to the patients' billing, and constitute the first tier of the triage system that is considered crucial in HMO practices. It is they who decide which doctor the patient calling for the first time is referred to. Among the determinants of this choice is the type of symptom the patient suffers from or the "group" he is assigned to. If, for example, a patient calls with mental problems, he is referred to Dr Peters, the doctor I have interviewed. In return, immigrant patients or patients suffering from chronic pain are referred to a colleague of hers "who has an incredibly good feeling for these patients". The medical practice assistants note the reason for the consultation in the electronic patient record and thus work up the initial categorisation given to a patient. [121] For Dr Peters, this type of "disease management" that builds on a strict division of labour, makes physicians' work a lot easier but also represents something unfamiliar to many physicians. She recounts:

> We've got an administration service, that means I never close an envelope or send a bill myself. If someone doesn't pay his bill I don't call him at home […]. I can delegate all this. […] In complex cases, like an elderly patient who needs a home-delivery of meals or *SPITEX* [home care organisation], I don't have to organise it myself and remain stuck in some waiting line. Instead I've got a nurse who does it for me. […] Today situations around the patient have become much more complex than perhaps in the [19]70s. If someone suffered from high blood pressure and perhaps heart rhythm disturbances, he received two drugs […]. But he was not told that the cholesterin [value] is important, that he should lose weight and that he should give up smoking. That was not done back then. And today that's part of it, that's really „disease management". You don't just hand over a pill by saying that it will all get better. And it's a lot easier today to share it [workload] with others instead of doing it all ourselves. (Dr Peters)

[121] Stein (1998: 96) criticised that such procedures fragment the treatment of "the whole person".

Attached to such practice models is the vision of enlarging the tasks of medical practice assistants in so far as they are responsible for monitoring the patients' weight, their visits to a walking group, their smoking and eating behaviours, and the like. Physicians would thus still be responsible for these things but delegate them to their staff.[122]

However, authors writing critically about managed-care instruments such as gatekeeping emphasise that there is a fundamental difference between a caregiver and a gatekeeper. Li, for example, states:

> The caregiver provides care and concern to a person in need, healing if possible, helping always. […] In contrast, the gatekeeper minds the gate, letting some persons through and keeping others out. The function of the gate is to restrict access. The gatekeeper serves the interests of the owner of the gate, not of the people trying to get through the gate. (Li 1996: 918)

Later studies have confirmed this conclusion, noting that the gatekeeper system does not meet patients' preferences for specific physicians or clinics, and that these "[e]fforts to restrict patient choice are likely to be strongly resisted" (Rowe & Calnan 2006: 5). In Switzerland, of course, the HMO system is not mandatory, so patients are free to choose if they want to be insured in that way (made attractive with lower premiums) or in the "classical"[123] way. Dr Debrunner experienced that many patients choose an HMO insurance contract but do so without accepting a limitation of choices. These patients usually do not wish to have one specific family physician. Furthermore they do not regard the family physician as the one responsible for treatment, but as a means to gaining referrals to specialists. Such situations hinder Dr Debrunner's "quality ideals" of medical work in a managed-care sense. The lower premiums of the HMO insurance model also attract socially deprived patients with an immigration background. He perceives the collaboration with these patients as being intense and ambivalent: On the one hand, they bring diversity and enrichment to his job; on the other hand, however, they sometimes conceptualise health and ill-

[122] In this context, Dr Peters noted that in her practice the older generation of doctors is not used to this kind of delegation, whereas the younger doctors have learnt to share responsibilities.

[123] This includes for instance a free choice of physicians, non-regulated access to care, and fee-for-service payment models.

ness in ways that he is not familiar with at all. Shared decision-making, one of his main conditions for good medicine, is made impossible through limited communication. In some cases non-verbal communication thus replaces verbal communication. Unhappy about such situations, he talks about performing "veterinary medicine".[124]

5.3.2 Efficiency and quality

The managed-care rationale considers efficiency as a central instrument of improvement and cost reduction. It is among the earliest and most often used terms in medical quality discussions, having been applied by Deming, Donabedian, and many other pioneer "quality gurus". In the following quotation we see how this industrial concept was translated from industry to health care:

> Care is also wasteful of resources, and costlier than it needs to be, when it is produced inefficiently. This happens, for example, when physicians do the work of nurses, or nurses the work of aides. […] Thus, costs are increased, without corresponding increases in quality, because of inefficiencies in the methods and the scale of production. (Donabedian 1980: 7)

Donabedian (2003: 9) defines efficiency in health care as "the ability to lower the cost of care without diminishing attainable improvements in health". He distinguishes between three types of efficiency, "clinical efficiency" (concerning clinical decision making such as prescription), "production efficiency" or "managerial efficiency" (e.g. labour division among staff), and "distribution efficiency" (e.g. adapting resources to specific social groups) (ibid.: 10). Howard F. Stein (1998: 90), a social anthropologist and radical critic of managed care, stresses that its underlying business approach may work in "the glass bubble of 'management'" but not in medical practice. This is mirrored in the notion of efficiency that is applied virtually as a synonym for quality, yet often in a sense that does not correspond with professionals' perceptions of good care. Alistair Donald describes this in the context of American psychiatry:

[124] Another doctor whom I have interviewed used the same terminology to describe his feeling when treating immigrant patients whose language he does not understand. It does not seem to be an HMO-specific problem but rather a matter of time pressure. I interviewed two doctors who have many immigrant patients, and I perceived them to be very passionate about these patients and willing to invest a lot in trying to communicate with them.

> Efficiency is good medicine and treats suffering the best. This is a radical reformulation of the clinical space, the irony of which is that morality at the level of public health has produced ideas of clinical practice which do not translate to actions which feel authentically therapeutically 'quality-like' to many actual clinicians […]. (Donald 2001: 432)

In much the same way, the family physicians I have interviewed also struggle with this term that stems from a context so alien to medicine. They criticise the causal rationality, whose byword is "more efficient equals higher quality", because its reverse logic would mean that physicians are to be blamed for illness and high expenses. One physician notes:

> People increasingly think that physicians are to be blamed for the existence of so many sick people and so many elderly sick, that their work is of low quality, of low efficiency. And I think that a discussion emerges there that does no good at all. (Dr Quinn)

Family physicians claim that quality control raises additional costs because it is complicated, time-consuming and detached from their medical practice. Furthermore, they have to meet the expenses for quality assessments themselves. None the less, they also adopt this causal rationality when they say that the establishment of family medicine, as the basis of the health-care system as well as patient-centered care, reduces health costs (Stewart et al. 2000; Chan 2007; Frankel et al. 2003b: 264). Although there have been attempts to provide evidence for this view in other countries, family physicians criticise a lack of Swiss family medicine-specific data that could responsibly shape and specify current quality discussions and that illustrate the actual relationship between family medicine and its economic effects. Interestingly, here, all actor groups defend their practice models and rationales with cost-containment arguments.

Despite the increasing importance of cost-efficiency and its aim at standardising individual ideas of efficiency since the rise of cost-containment discussions in health-care systems since the 1980s (Kälble 2005: 7), individual perceptions of what efficient practice implies have remained in place. In daily practice, family physicians sometimes consciously decide against guidelines or division of labour because they ground their decisions on different reference systems, not merely on administrative

or biomedical ones. A variety of epistemologies have been merging with professional action, reaching from biomedical knowledge to biopsychosocial, contextual, tacit, and economic knowledge, to name only a few (s. chapter 6). It is thus difficult to graphically and numerically demonstrate family physicians' trajectories of decision-making in a technical and reproducible manner. Family physicians emphasise that certain domains and situations in medical practice exist where procedures can be clearly delegated among the different actors, or where medical guidelines can be applied to diagnose and treat certain symptoms. Yet, they have also pointed out that in medical practice "doing things rightly" and "efficiently" are highly relative concepts and thus are never unequivocally clear.

On the one hand, some physicians favour the division of labour, the core idea of managed care, over broadly conceived responsibilities, because that notion better frames the field in which they feel competent. One doctor noted that she does not want to be at the same time a "priest, doctor, pediatrician, […] and gynaecologist" because she was not trained to handle all those roles. She adds that she would probably manage to handle them somehow, but that "this is not good care" (Dr Peters). Other physicians, on the other hand, appreciate the convergence of different roles and decision trajectories that occur when the division of labour is definitely set aside:

> Suspecting a tendovaginitis, I prescribe a support bandage to the patient, particularly as a signal to her employer so that the patient can rest her hand. I rub her wrist with ointment and adjust the support bandage myself. Actually my medical assistant could do this as well, but I've got the feeling that it is important to rub her wrist myself. (Dr Aeschbacher)
>
> When I suspect that the patient has a problem I sometimes use somatic treatments to initiate a conversation. Iron infusions are a recent example, they are quite fashionable at the moment. […] This could be done by the medical assistant but there have been situations where I've done it myself. In this way, I get a quarter of an hour to talk to the patient. And as long as the infusion is running the patient cannot leave. *(laughs)* I then try to strike up a conversation which sometimes brings out huge problems which the patient suffers from.
>
> *How does this additional knowledge about the patient serve you in terms of further treatment?*
>
> Often these patients call me if they need something on short notice. Due to the

> knowledge I've gotten about the patient and about his problem, I don't need to see him for an extra consultation. I can handle it in written form. (Dr Gebhard)

As we see by the way of these examples, trajectories of medical decision-making and treatment do not always make sense from an external cost-assessment point of view, but they do have a meaning for the people involved and are thus not necessarily chosen at random. Accordingly, what efficiency means in daily practice is highly situational and heterogeneous. Suzanne R. Kirschner & William S. Lachicotte (2001: 450) even state that the homogenization of disorders which is brought about by cost-effective handling simply ignores the idiosyncrasy and nonlinearity of illness episodes. In this sense, observe critics of the dominant quality module, "the managed care algorithms […] actively encourage a notion of personhood and a […] 'science' more suitable to business and consumer culture" (Donald 2001: 436). "Caring under managed care", as Stein (1998: 82) notes, "occurs despite the structure, not because of it".

It is therefore characteristic of managed care that its rationale of rationalisation and standardisation has been implemented "in an attempt to streamline practice and […] action according to specific diagnoses in order to make practice efficient" (Donald 2001: 429). Therefore, managed care is to replace former forms of professional action with new "social practice[s]" (ibid.: 430). Among these are mainstreaming practices in relation to the explanation and treatment of illness episodes, and the channelling of patients and of physicians responsible for them (Rylko-Bauer & Farmer 2002: 488). James T.C. Li (1996: 918, emphasis in original) believes the establishment of market logics in medicine to be dangerous, due to its "transformation of physicians to interchangeable, dispensable workers", but also due to the "transformation of the *patient* to the status of commodity" (s. also Posner et al. 1995). For the staff that Donald accompanied, the managed care rationale replaces „actual" patients with "virtual" and thus unknown patients (Donald 2001: 433). This is what Stein (2001) meant when he undertook research on how these new structures "depersonalize and dehumanize" health care (Rylko-Bauer und Farmer 2002: 488). One interviewed HMO physician (Dr Peters), however, considers this de-contextualisation to be a very helpful element of her work, stating that decision-making may be more "neu-

tral" than in cases where whole families are treated by the same family physician, and that this is the reason why she appreciates this "disentanglement". This ambivalence between closeness and distance will be further elaborated on in section 6.2.2.

5.3.3 From bricoleurs to entrepreneurs?

In his book chapter on quality management and self-management, Bröckling (2000: 155) analyses how "entrepreneur" became the "leitmotiv" of neoliberal subjectivity. Particularly important in this respect is the altered perception of variation and heterogeneity that goes along with this motivic transformation: For a bricoleur, deviation from the mean is the norm, whereas for the entrepreneur variation causes waste (s. Deming, chapter 3). As critical voices claim, neoliberal forces attempt to homogenize actors and processes (Gershon 2011: 546), to promote a "corporate transformation of health care" (Salmon 1990), eventually leading to a "corporate medicine" (Stein 1998: 79). In this respect, managed care is thus called a "one-size-fits-all model" (Rylko-Bauer & Farmer 2002: 490). In his article *Primary care practices are full of surprises!*, Benjamin F. Crabtree (2003: 281) states that primary care practices are places of "surprise, variation, and complexity" and thus require "bricolage and improvisation" (ibid.: 282). Stein (1998: 81) argues similarly by stating that "[c]aring can be structured, but it must leave room for uncertainty, ambiguity, novelty, surprise". And Donald (2001: 436) describes how "the businessman as a cultural cynosure replaces the clinician as the bearer of Hippocratic wisdom".[125] However, I believe that the evidence warrants a less extreme assessment than found in the critiques of dichotomy by Donald and many others, arguing instead for a discourse of extension and challenge rather than replacement. Rather than a new, monolithic and highly regulated role, physicians find themselves between "two professional worlds" (Kirschner & Lachicotte 2001: 454): They are in the role of "double agents" (Angell 1993; 279), brought about by the extension of their former role: For some, this double position does not correspond to their ideas of good care or the way they have been trained, and thus becomes the occasion for a crisis in professional identity

[125] S. Parsons (1970) who perceived medicine as being incompatible with an entrepreneurial rationality.

(Donald 2001: 429ff), whereas for others it represents a new type of medical practice which they enjoy. One HMO doctor (Dr Peters) emphasises that this additional role is motivating her and her team: Because her practice is organised as an open corporation, all employees can hold stocks, a fact which greatly enhances her sense of shared responsibility. Being busy with both medical practice and business affairs creates a work situation filled with variety that she perceives as interesting. The business-like structure of many HMO practices implicates a re-organisation of procedures, a strict division of roles and the establishment of documentation practices.

5.3.4 Enhanced bureaucracy and organisation

The corporate transformation of medical practices has resulted in narrowly structured and documented processes of work. One HMO physician (Dr Peters) points out that in her practice every track taken at every level by patients is documented in written and electronic form, so that "no mistakes occur" and everything can be reconstructed. All steps are conducted in a specific order, meaning that a physician cannot just walk into the laboratory, but must fill in a form first. This doctor complains that in smaller practices the different rooms and physical zones in the practice space are open, so that physicians communicate their orders to the medical practice assistants in oral form, which she considers "a catastrophe". The growing shift from paper forms to digitalisation is one aim of her HMO practice. She reports that her practice is thinking about recalling patients for follow-up vaccinations via text messages. In her view, such innovations "truly improve quality". She explains:

> Good quality means that the second vaccination really takes place […]. I don't remember if this person was vaccinated half a year ago and thus needs a follow-up. We then develop a system where the computer tells us that Mister Meier needs his follow-up vaccination on 6 November. The aim would be, then, to send a text message to Mister Meier that reminds him of this appointment. These are things that clearly improve quality. (Dr Peters)

She emphasises that in a rural practice such things might not as easily be forgotten as in an urban group practice, because in the former physicians usually meet patients also outside of the practice. In a large group practice where "one does not know everything about the patient anymore", this is not feasible. Another HMO doctor (Dr

Debrunner) states how the increased number of physicians working together requires a larger infrastructure, a larger staff (e.g. more medical practice assistants and medical therapists), an increased "team organisation, team development and care for the team". Such large infrastructures require a certain budget and overhead which are not affordable in smaller practice models. In questioning the claimed benefits of managed care, Barbara Rylko-Bauer & Paul Farmer state critically:

> […] administrative costs have soared; control and management require large bureaucracies […]. As for the promised efficiency, it has been accompanied by layers of bureaucracy, limits on patients' choice of providers, excessive focus on documentation of services provided, and a myriad of plans, each with different requirements for pre-authorization and selective contracting […]. (Rylko-Bauer & Farmer 2002: 487)

In his literature review, Kälble (2005: 8) writes that physicians generally perceive increased bureaucratisation and documentation as very time-consuming, leading to a "drop in care quality". He goes on to say that "[p]hysicians tend to see themselves more and more as being forced into the role of rationing agents and entrepreneurs" (ibid.). In an older article Posner et al. (1995) show that American physicians have come to see the rising bureaucratization of their work as a threat to their professional autonomy, and therefore have strongly resisted it. Among the family physicians whom I interviewed, the increase in paperwork was generally perceived as a time-consuming burden.[126] Yet, one female doctor noted that the writing of reports, for instance, may also have a positive effect:

> The report which I must write for referrals is a quality control: When I need to formulate it in writing, I realise that I haven't conducted the whole procedure according to the guidelines. That's a quality feature. If I could write a report for every patient that would probably be very good. (Dr Quinn)

5.3.5 Institutionalised forms of quality control

HMO practices are legally required to carry out quality control (Gebert 1980: 133). In the first years of managed-care models in Switzerland, quality was controlled by

[126] The medical historian Eberhard Wolff (2008: 57, author's translation) has documented that already in 1920 the Swiss medical fraternity complained about being degraded "from the healer to the 'writing slave'".

the practices themselves. In Dr Debrunner's (insurance-owned) practice, for instance, the assessment of quality activities still takes place internally, following *EFQM*[127] methods. In 1999, however, a group of physician-owned managed-care organisations founded *EQUAM (External quality assurance in medicine)*, an independent foundation responsible for quality control and certification thereof in medicine (Huber & Hess 2007: 72). That is why in Dr Peters's practice the assessment, certification, and re-certification procedures are conducted by *EQUAM*. Such evaluation institutes specialise in awarding quality certificates to HMO practices as well as to independent practices (Baumberger 2005: 180). In the case of some health insurance companies, the amount of their payments to HMO physicians networks depend on the existence of an EQUAM certificate (Huber & Hess 2007: 73).

Different from non-*HMO* practices, physicians who work in such systems have work-time available for further education, team sessions, quality circle meetings, supervision, intervision, and the like. Additionally, there is a check list of rules that need to be followed[128], waiting times are registered[129], patients' satisfaction is evaluated, there is an internal CIRS (critical incidents reporting system), there are weekly case conferences and regular appraisal interviews take place. Quality activities are a requirement of HMO practices which are covered economically, in contrast to non-HMO practices where physicians are not reimbursed for quality activities and thus have to get them into their regular working hours. This is mentioned as one major benefit of HMO practices:

> There's more time available for education, for the realisation of education programs. We conduct various quality circle meetings, not just one in two weeks, but on a more regular basis. We've got team meetings and supervision meetings. We can do this during working hours just because it's desired in this system. […] That's the great advantage [of it]. (Dr Debrunner)

[127] This is a European TQM tool.

[128] For example, closing the door separating the waiting room from the medical practice assistants' desk, to guarantee privacy.

[129] This is calculated for each doctor: How long do his patients have to wait on average in the waiting room, but also how long until they get an appointment?

Quality activities are thus not only mandatory but institutionalised and part of HMO practice structures. The above quoted doctor therefore calls HMO practices "quality versions" of practice because they mirror a broad medical knowledge resulting from intense team collaboration. However, he stresses that the institutionalisation of quality activities is very expensive and therefore can by no means be borne by practices that are not supported by insurance companies and whose income depends only on Tarmed tariffs.

5.3.6 New forms of agency?

In Switzerland the context of managed care is somewhat different than the one that American critics refer to. Here, working in an HMO practice, as well as being insured in an HMO contract, is still voluntary. There are various reasons why physicians choose to work in such settings. One interview partner (Dr Debrunner) used to have a single practice when he was younger. After having worked for many years at a university department for medicine, he considered the HMO practice as a way to re-enter the practice of medicine without having to establish a new practice from scratch. In addition, he told me during an informal talk that he saw this HMO employment as a personal experience, because he felt rather critical of the economisation and specialisation of medicine. The situation of another interviewed HMO doctor (Dr Peters) is somewhat different. Before working in an HMO practice, she worked in a double practice, where she perceived the working conditions as very demanding and unsatisfactory. Being a mother of two small children at that time, she worked part-time as an assistant in the single practice of a family physician. She remembers that the many consultations per day as well as the home visits and night duties "were a strain". For her work she received a „modest salary without any entrepreneurial responsibility", because her employer did not want her to hold an equal status. As a consequence, she decided to take on a 50%- employment contract in a large urban HMO practice. The managed care structure combined with her part-time employment and her entrepreneurial responsibility have led to a much higher satisfaction in her case. She recounts that the reduced number of consultations per day, the delegation of administrative work, and the team work have enabled her to concentrate „on what I'm good at". After a while she cultivated an interest for the entre-

preneurial aspects of the practice, and thus became a member of its management board, which she perceives as a "good balance to the clinical work".

Paradoxically, to both physicians this tight organisational structuring enables a free, calm, relieving, and democratic style of work. This clearly contradicts critical accounts of managed care as a framework that limits professional autonomy. Yet, keeping in mind its non-mandatory status, the decision to work in an HMO practice is still one that physicians make. That is why my interview partners who work in an HMO setting are rather positive about their working environment. To them, HMO practices serve as spaces where different types of work and rationales are combined. Another reason for choosing to work in such a setting is the collaboration it affords with a group of physicians. To them, working in a team has the benefit of professional exchange and feedback, locum and thus continuation of treatment processes in case of doctor's part-time work or absences (facilitated by electronic patient records), shared responsibilities, and protection against or assistance with legal cases.

So in the Swiss context the combination of both clinical and entrepreneurial reasoning does not necessarily create a "feeling of displacement" among physicians (Kirschner & Lachicotte 2001: 455), but might actually promote a working style which they consider as highly convenient and of high quality. It would thus be simplistic to interpret these new practice models that have evolved out of economisation processes as being exclusively instruments of regulation imposed on physicians and patients. New practice models have also emerged because of the changing needs and preferences of both physicians and patients. New practice models not only guarantee fast and permanent access to care, or innovative styles of communication. They also provide highly structured working conditions, the possibility of working part-time, afford a more expensive technical infrastructure, and provide physicians with easy access to judicial support if needed. The fact that some patients and physicians abandon formerly idealised concepts, such as the life-long doctor-patient relationship and contextual knowledge about patients, and enter into new practice settings by choice, is often ignored by actors who criticise the economisation of medicine.

Doctor Notter | Stepping in his father's shoes

Dr Notter decided to become a family doctor because he likes the manifold symptoms and heterogeneous clientele in family medicine, and because he got the chance to take over his father's practice in the rural community where he grew up. There used to be a community hospital which was closed in the course of the Swiss hospital reorganisation, together with many other smaller hospitals in the rural areas. As a consequence, Dr Notter has the possibility of treating many patients who would be sent automatically to specialist doctors if they worked nearby.

Dr Notter is 30 years old, married and has two small children (pre-school age). His wife is responsible for the administrative accounting of the practice. He lives and works in the same house but emphasises that, in contrary to his father and his father's colleagues, his own generation tries to draw a line between private life and work. However, he stresses that this is not always easy. For instance, he does not feel comfortable when he visits the local shops and does not participate in the local sports clubs because to the population he would still remain "the doctor". Dr Notter's father keeps working one day per week but has put the entrepreneurial responsibility on his son. The practice offers regular services in the field of family medicine but also manual medicine and ozone therapy. In general, Dr Notter prefers "somatic" cases rather than patients who suffer from psychosomatic or mental illnesses.

Dr Notter is not very active in institutionalised peer groups but has a network of colleagues whom he approaches in case of medical questions but also if there are issues concerning the management of his practice. This kind of support is of crucial importance to him because the work in a single-handed, rural practice can be very lonesome.

Dr Notter feels ambivalent about the rising political activities of family doctors such as public demonstrations or the launching of political initiatives. He thinks that these activities do not motivate medical students to become family doctors but rather scare them off.

Doctor Odermatt | fighting for the medical needs of the rural population

Dr Odermatt lives and works in a remote rural area where about fifty percent of the inhabitants earn their living with farming and an additional employment in the industrial sector. When he moved to the town 30 years ago, the area suffered from a lack of medical provision. Doctors from the surrounding communities refused to continue their regular visits to the town, where they treated patients in the back room of a local restaurant. Dr Odermatt was familiar with the community because he used to spend his vacation there when he was a child.

Dr Odermatt is responsible for three communities (approx. 6'000 persons). Most of his patients are well known to him. A few years ago he started looking for a partner who would – after some years of collaboration – eventually take over the practice. He found a younger colleague with whom he shares his practice up to his retirement.

Dr Odermatt is widowed and father of three grown up children. He lives and works in the same place but has never had any trouble separating his professional activities from his private life.

During the past three decades Dr Odermatt not only witnessed developments in medicine (e.g. specialisation, increasing requests for work/life balance of the younger generation of doctors, the changed status of doctors, centralisation of health care delivery) but also changes in economic and social structures of the rural towns such as industrialisation, marketisation, individualisation, and migration from the area. People used to depend on strong social ties, shared what they had and depended on each other's support, whereas nowadays their living standards, ideas of a "good life" and the pressure to earn enough money have increased. Dr Odermatt is strongly concerned about these developments and feels obliged to support the local community as much as possible. That is why he truly hopes that his successors will be considerate of these local conditions and refrain from "ripping off" their patients.

Doctor Peters | Combining family life and doctoring

Dr Peters has a degree in internal medicine and is sub-specialised in psychosomatic medicine. After having completed her years of medical assistance in clinical departments such as surgery and obstetrics she was eager to work in the hospital setting.

However, her superiors considered her pregnancy and motherhood as a hindrance to her career and she felt impelled to continue to work in the ambulatory setting. She was employed in a rural practice for a while but soon realised that her employer would never place the entrepreneurial responsibility for the practice on her. The lack of responsibility paired with the long working hours and 24 hours availability brought her to look for another job. She was then employed in a large urban physicians-owned HMO practice with a flat hierarchy, strict interdisciplinary labour division, a broad age mix of doctors and fixed working hours. After a while she was offered to become a member of the management board and is now also the head of personnel. Working part time and having a family were at no point considered as a problem by her colleagues.

About two third of Dr Peters's patients are women who suffer from eating disorders. He is member of an internal quality circle, of an internal critical incidents board, of an external supervision group, an intervision group, and she receives single supervision from a famous professor of psychosomatics. Additionally, she visits a psychiatrist on a regular basis which is a requirement for doctors who are specialised in psychosomatic medicine.

> What is the kind of knowing in which competent practitioners engage? How is professional knowing like and unlike the kinds of knowledge presented in academic textbooks, scientific papers, and learned journals? (Schön 1993: viii)

6 Evidence and patient centeredness

Evidence and patient centeredness are among the core concepts of the modern quality rationale in medicine. They form key terms in the epistemological discourse that runs through the quality dispositive. In this discourse, the definition, range, production and application of medical knowledge is the main issue. In this respect, this discourse is about specific constructions of health, illness and patienthood, and about specific ideas of how appropriate medical decision making, also called "best practice", ought to function.

6.1 Evidence-based medicine

Evidence, here, is understood in a very specific and programmatic sense, namely as the core concept of *evidence-based medicine (EBM)*, and linked to a defined way of knowledge production and application. It is considered as both an "epistemological and a methodological concern", as Engelke (2008: S2) notes generally about evidence. Since the 1990s EBM represents a predominant and controversial discourse in the medical disciplines and related fields. It has turned into a synonym for medical quality, defining *gold standards* and *best practice* guidelines. EBM is defined by its proponents as:

> […] the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research. (Sackett et al. 1996)

Clinical evidence encompasses a specific type and understanding of knowledge as well as a specific way of producing and applying that knowledge. EBM depends on a fixed definition of disease categories "because the data from various studies can be compared only if disease entities and trial procedures are taken as stable" (Ecks 2008: S81). The quality and validity of evidence is distinguished on five different levels, which are hierarchically structured: Randomised controlled trials (RCTs) are the most reliable sources of evidence for clinical decision-making, followed by cohort studies, case-control studies, case series and expert opinion (Greenhalgh 2003: 80f; Tonelli 2006: 249).[130] Concerning the latter, Donabedian noted that the opinion of experts serves in fields where no scientific evidence exists yet. But expert opinion is considered only as a provisional solution until the according scientific evidence is supplied (Donabedian 2003: 68).[131] As this epistemological hierarchy shows, "best" evidence "conjures up notions of information or `available facts' which have an independent existence, thus enabling a particular argument or hypothesis to be `proved' or `refuted', or its validity to be established" (Barbour 2000: 155). Thus, deductively obtained evidence free from individual context, opinion and experience is still considered as the "gold standard" for diagnostic and therapeutic interventions, calling for professionalization and quality improvement of medicine (Lagerlov et al. 2000;

[130] Although there are voices who claim for the application of qualitative approaches to broaden "evidence" in EBM (e.g. Greenhalgh et al. 2005a: 448), it is not clear how to provide the necessary databases for EBM-relevant qualitative studies, and how it can be assured that qualitatively derived "evidence" does not consist of a scattered, unsystematic pot of data but as a tool which can be used as a whole (Barbour 2000: 159ff).

[131] The production and application of a systematic, scientifically grounded corpus is defined as one characteristic of a profession. Schön (1993: 23), for instance, notes that "[t]he systematic knowledge base of a profession is thought to have four essential properties. It is specialized, firmly bounded, scientific, and standardized". Continuing with the application of this systematic knowledge he points out that "[t]his concept of 'application' [of general principles and standardized knowledge] leads to a view of professional knowledge as a hierarchy in which 'general principles' occupy the highest level and 'concrete problem solving' the lowest" (ibid.: 24).

Grol 2001; Vogd 2002; Boyd et al. 2005; Portwich 2005). The appropriateness of treatments is therefore to be decided based mainly on clinical epidemiological knowledge. In this sense EBM produces a definition of "what should count as good evidence and what should not" (Ecks 2008: S81), and, as a consequence, what counts as quality and what does not. Over the last decade and a half, EBM became a metaphor for best-quality medicine on which future health policies as well as daily medical decision-making are to be based. EBM thus serves as an argumentation device on different levels, reaching from political discussions to daily medical practice (Le May et al. 1998; Gabbay & Le May 2004).

Critical voices, among them some interviewed physicians, claim that EBM is not something new but rather "old wine in new skins" (Dr Lehner, s. also Bleuer 2000). One family physician, for instance, critically remarked:

> Evidence-based medicine: one acts as if it was a new invention. If I hadn't practiced evidence-based medicine from the beginning of my career the way I still do it, I would never have been allowed to do this job. It has now turned into […] a label und many people don't realise that it's nothing new at all. Guidelines have existed since I began to practice medicine. Already as students we were instructed that way. […] [To learn about] a disease pattern in terms of pathogenesis, symptomatology, diagnosis, therapy. Basically, it [EBM] is nothing else than that. (Dr Lehner)

Certainly, in terms of the underlying medical concepts and their shaping of medical practice through algorithms, EBM is not new but represents the further development of modern medicine.[132,133] Pwee (2004: 413) for instance traces the philosophical

[132] In 1978 and thus before the emergence of EBM, the German physician Manfred Pflanz (1978: 10, author's translation) called for the systematisation of medical action in terms of diagnostic and therapeutic standards. He considered these standards as a way of improving care of the "average patient" and as a means of "internal quality control".

[133] In a recent article titled *What's the difference between a hospital and a bottling factory?* (Morton & Cornwell 2009), the authors propose comparing hospitals to repair shops, due to the formal similarity between their diagnostic tools. They see successful repair shops as having the potential to teach hospitals about fast, accurate, and objective diagnosis (ibid.: 339). The authors build their arguments on the classic psychological study on expert fallibility by Fischhoff et al. (1978). Using the example of a car that does not start, Fischhoff et al. (ibid.: 331) present a failure tree which lists possible problems that could lead to repair, such as "battery charge", "starting system", "fuel system", "ignition system", and "all other problems". The authors propose transferring this reasoning to other areas such as medicine,

roots of EBM back to the 19th century, when medical decisions followed a "numerical method" that resulted from the "careful observation and collection of data". EBM in its current form applies the methods from clinical epidemiology to produce medical knowledge and develop guidelines (ibid.). Yet, even though medicine has always produced new knowledge about symptoms and illnesses, the systematic way in which medical knowledge is now produced, diffused and transferred to practice guidelines seems to be extraordinary. The "standard human" that this approach allows one to create has not only had a heavy influence on "medical theory, practice, education, and training" (Epstein 2009: 42)[134] but, as I would add, also on the assessment, control and sanction of medical practice. The modern quality rationale and its materialisation through standards, guidelines, assessments, audits and monitoring not only grounds itself on a narrow idea of evidence in the sense of EBM (Greenhalgh 2007: 279ff) it also depends on a reified and detached idea of illness and body. In this regulatory sense, EBM not only produces standard patients, bodies and illness trajectories. It also creates standard treatment trajectories and, as a consequence, standard physicians who are to orientate their work towards them. The ambivalence inherent in these different functions is mirrored in family physicians' twofold perception of EBM as both a help and a hindrance to their work.

However, what I consider as a new and wide-reaching element is EBM's compatibility with the rationales of other actor groups, services or functional systems, such as health insurance companies, law, other medical specialties or patients. In their *Lancet* essay Sweeney et al. put it bluntly:

> Evidence-based medicine is the new deity in clinical medicine: physicians worship it, managers demand it, and policy makers aspire towards it. (Sweeney et al. 1998: 134)

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where "one could construct a tree headed by '3-month old infant cries more than 5 minutes'" (ibid.: 332) and the like. A failure tree depicts various possible scenarios and assigns probabilities to them (ibid.). In clinical decision-making, I consider the differential diagnosis, its use of the Bayes theorem, and of course the EBM rationality as medical pendants to the mechanism of the failure tree.

[134] For instance, medical students work with „standard patients", i.e. with actors who play patients using a certain script.

So, EBM seems to be a common denominator, a shared concept that all the different actors in some way or another relate to and make use of. Yet even though, 15 or more years after the first EBM publications appeared and the peak of the EBM controversy (together with its strong pro- and contra-positions) seems to have passed, with EBM now integrated into daily medical decision-making (Ecks 2008: S82), I see it as an important and continuing contributor to tension in the quality conflicts among various health-care actors. Its guidelines not only create tools for clinical decision-making but also for challenging, criticising or sanctioning medical work. One physician noted:

> This [sanctioning of non-adherence to guidelines] is a dangerous tendency because in the end the doctor is made responsible for the failure of a therapy. What follows is that one begins to avoid getting one's fingers burnt. You get rid of the difficult ones [patients]. […] No, we should not go so far as to have experts deciding what ought to happen in the consulting room. […] We should not let it go that far. This offends our professional ethics. (Dr Frei)

From a Foucaultian perspective (Foucault 2005: 78), this specific production of medical knowledge in the form of clinical guidelines serves a regulatory function: Only the production of guidelines renders a thorough external regulation of physicians' work both thinkable and practicable.

6.1.1 Clinical guidelines

EBM is materialised in clinical guidelines which serve as a transmitter of the evidence gained from epidemiological studies to medical decision-making. They are created from the "best" available evidence and developed in a long and complicated procedure of selection, establishment and further development. On the one hand, guidelines are defined as tools to provide equal medical treatment for all. This is grounded on the idea of providing equal access to care for all social groups, but also on the assumptions, first, that treatment is standardisable, and second, that physicians understand and apply these guidelines in the same manner. In this respect, evidence-based "knowledge is viewed as a manual" in which information can be looked up (Tsoukas 1997: 830). On the other hand, guidelines should provide physicians with quick summary of the latest research findings so that they do not spend long hours

browsing journals. Accordingly, guidelines are created "to condense knowledge into practice" (Grol et al. 2005: 61). They can be either prescriptive or proscriptive, i.e., they either foster certain interventions (increase) or call for the reduction of treatments (rationing) (Carlsen et al. 2007: 974). Physicians have different possibilities of accessing guidelines, among them current issues of medical journals, CME meetings, online newsletter services such as PEARLS[135] or exchanges with colleagues.

Guidelines are based on the idea that it is possible and necessary to define standard procedures of medical treatment. In this respect, variations in treatment are regarded as "variations in quality of care" (Mabeck & Kragstrup 1993: 32). Therefore, so the proponents argue, variations need to be eliminated by standardised guidelines. These "algorithms of care" are based on the assumption that illnesses and symptoms are "conceptualizable as an algorithm" (Donald 2001: 432). The disappearance of individual patients and contexts in the RCTs, with the resultant produced average and thus anonymity, plays an important role in creating standards as objective instruments (Busch 2011: 68). The methodologies used for guideline development, but also this exclusion of context, result in a certain anonymity, and consequently in an unquestioned matter of fact (Tsoukas 1997: 831). „Even if we know who established them", Busch (2011: 29) notes, "standards take on a life of their own that extends beyond the authorities in both time and space".[136] Yet, as Tsoukas (1997: 830, emphasis in original) emphasises, information is not "as neutral as […] a planet or a stone: it is there because *someone* put it there". Therefore, information is not only constructed and thus open to interpretation and meaning; it also has a specific purpose.

Family physicians perceive medical guidelines as indispensable instruments that assist them in making clinical decisions. Medical guidelines thus form a constitutive part of medical practice (Olesen & Lauritzen 1997). They give "important stimuli"

[135] PEARLS means "practical evidence about real life situations" and is an information service of the *Cochrane Library*.

[136] For instance, critics note that the influence of the pharmaceutical industry on the development of guidelines development is high but seldom discussed. Taylor & Giles (2005) write that 35% of the guideline authors are paid for by the pharmaceutical industry.

(Dr Jakob), serve as orientation grids and aims, check lists, as a test of one's own state of knowledge, and as a tool to question one's routine, as family physicians noted. Yet, despite these attempts to produce an instrument that would render an equal treatment of patients feasible, the translation of a standard into the terms of a particular context is often regarded as challenging. As Van Woerkom (2010: 348) noticed pointedly, "[p]urely objective reasoning cannot determine what to notice, what to attend to, and what to inquire about". In this respect a systematic overview lists the most common reasons for physicians' non-adherence to guidelines, showing physicians' perceived discrepancy between research evidence, which creates "ideal" patients, and their daily experiences with individual patients (Carlsen et al. 2007: 972ff). Two of my interview partners summarise the reasons for this challenge as follows:

> The guidelines don't work because they were developed in a specific setting where it [symptom, illness] appeared. The setting in which we work is completely different than where these guidelines were developed. And among our settings every single setting is different. The practice of one doctor is different than the practice of another doctor. Why? Because different people are behind it, with different dispositions and different hobbies [clinical interests and strengths]. (Dr Lehner)

> At times it's because of the side effects that I can't follow the guidelines. Sometimes it's because of the missing cooperation [between doctor and patient]. In the case of elderly patients one has to proceed a bit differently. Only a few guidelines exist for elderly people. It's simply a different [kind of] medicine. Yes, such are the reasons. Sometimes I think that it [guideline] just doesn't fit the patient. Or the diagnosis is not so clear. Then you have to proceed in a trial-and-error manner. With migrants the reason sometimes lies in the fact that one doesn't really understand them. Or also if a patient has only a basic health insurance contract [and no additional one]. Then not all drugs are paid for. (Dr Frei)

Further reasons listed are variations within the pathologies, multimorbidities, symptoms resistant to treatment, specific patients' living contexts or preferences and specific environmental factors (s. also Mabeck & Kragstrup 1993: 32). The prevalence and type of symptoms may thus vary, for instance, between countries. A doctor recounts that "it is impossible that Holland and Switzerland share the same recommendations. People from here [where I practice] work in the agricultural sector. They

have, for instance many more streptococcus infections than people living in New York, where they [physicians] conduct many more HIV tests and such things“ (Dr Tanner). Another example was related in one of the quality circle meetings which I attended. The invited infectiologist pointed out that North-American borreliosis guidelines cannot be translated to Europe due to the different parasites, different borreliosis species and forms, and different symptoms. Additionally, physicians state a discrepancy between the proclamation of guidelines and the actual availability of them. A physician with a lot of HIV/Aids patients noted:

> I don't [want] my patients to become guinea pigs of the pharmaceutical industry. If they are not necessary, I try not to use the latest substances, but evaluated, evidence-based substances. […] I use products that have been applied on average for 5 years, or that have been tested on an average of 5'000 patients. That's just a rule of thumb. With it I'm certain, in a way. […] Unfortunately I can't apply this rule of thumb in the field of HIV or hepatitis C. These are delicate issues. Particularly in practice I often find myself very exposed, because I use new substances which leave me unable to say whether the kidneys will perhaps be damaged in ten years' time. […] And from a legal perspective, in terms of my liability [this is delicate]. If a patient says: "Yes, doctor, you gave me the latest [substance], that's great, but now my kidneys don't work anymore." […] In that case I expose myself in a big way. A university hospital which prescribes the same substance has a different background [in terms of legal protection] which I don't have. (Dr Quinn)

When treating polymorbid conditions, medical guidelines often lose their working force, and physicians have to decide on further treatment on a much broader basis, which forces them to set clinical priorities. In such cases medical-treatment guidelines are sometimes adapted or ignored. These omissions happen on purpose, for instance due to a different setting of treatment priorities or to interactions of pharmaceuticals (Kissling 2002). One doctor illustrates this as follows:

> Sometimes I check things differently than I ought to. Hence I decide to omit something in this case because it doesn't make any sense to me. Either due to polymorbidity or due to age. In such cases I omit something on purpose. In that way I can stand behind it. If I went through a quality assurance program, I would be asked why I didn't do it that way. Perhaps I'm wrong, perhaps they [quality experts] will say that it's not about such things. The question is how quality is measured. I find it difficult if quality assessment structured the doctor in such

> ways. It's not because I want to defy control but because I think that it's too limited. (Dr Gebhard)

The intertwining of different symptoms and illnesses thus creates a "unique case" whose treatment is apparently hard to standardise (Schön 1993: 64). A doctor emphasises that here he cannot treat "the sum of symptoms" (Dr Jakob) because that would lead to an unreasonable quantity of drugs and controls. In a quality circle meeting about this issue, one doctor said that he usually implements medication slowly when a patient gets diagnosed with diabetes. This means that he does not introduce all the required medications at one time, but instead introduces them step by step over one year's time. He cites two reasons for this, first, a psychological one: To begin by going from zero to four medicaments is too much for the patient. Second, by introducing medicaments step by step, the doctor maintains control over the effects of the medicaments and may, in cases of the patient's bad reaction to the therapy, be able to distinguish between side-effects of the medicaments one by one, and the same between counter-indications from the several medicaments.

So, all these different statements point to the relative role that guidelines play in medical work. Hence, many of them cannot be applied one-to-one in a "cook-book" manner (Gabbay & Le May 2004; Grol et al. 2005: 73f), but in a selective, balanced way as Busch notes:

> Standards are recipes for reality, or perhaps for realities. Like recipes for foods, they may be well- or ill-conceived, the subject of careful analysis or of a slapdash throwing together of ingredients, and they may result in a tasty dish or one that is barely palatable. Moreover, like recipes, they implicate both people and things. Even when using the same recipe, the master chef and the novice may well produce quite different things. Some recipes must be followed extremely carefully if the expected results are to be achieved, while others can be easily modified. (Busch 2011: 73)

This last sentence points out the ambivalent character of guidelines: Do they serve as pure "recommendations", as I was told in my first *EQuiP* summerschool in 2008, and are they open to physicians' choice and "local convention" (Posner et al. 1995: 477)? Or are they external "rules" for best practice, and thus bear the potential of

undermining professional autonomy (Vogd 2002; Ecks 2008: S82), not least through external sanctions of various kinds?

Health-care actors do not agree on the liability of guidelines. Therefore, guidelines do not have a uniform status, but different ones according to the setting and context in which they are applied. Engelke notes:

> Proponents of evidence-based medicine argue that it helps preserve and promote best practice by shifting the profession away from 'ego-based' and 'eminence-based' medicine, a state of affairs in which the good and great might act on their own authority, rather than the findings of science. Critics of evidence-based medicine caution that the utopian vision of doctors with instant on-line access to the gargantuan EBM database robs practitioners of alternatives and concomitantly of agency. It is important not to overstate the pro and con positions […]. The vibrancy and potentials of any discipline or profession can often hang in a delicate balancing act between rigorous quality controls of what counts as 'good' evidence and a recognition that these controls must remain flexible lest they blinker a professional vision. (Engelke 2008: S15f)

It is this field of tension between recommendation and regulation that frames family physicians' ambivalence towards EBM guidelines and consequently towards quality assessments that are grounded on the adherence to these guidelines. In his book about standards, Busch defines this specific form of power as „the ability to set the rules that others must follow, or to set the range of categories from which they may choose" (Busch 2011: 28, in italics in the original). Family physicians' work constantly oscillates between this "must follow" and "may choose", a range which is expressed in a doctor's perception of guidelines as "almost mandatory" (Dr Escher).

There exist decisive arguments that call for a definition of guidelines as mandatory rules. Best & Neuhauser (2005: 310), inspired by Deming, state that "[p]atients treated off best practice guidelines receive unacceptable variation in care. […] Such variation causes waste and harm". Concrete examples for this normative stance are the British *NHS* whose quality control of physicians (and their sanctioning) is strongly based on their adherence to medical guidelines (Contencin et al. 2006). Another one is the Swiss health insurance companies' critical queries on specific prescriptions that family physicians have discussed about. So, from this perspective guide-

lines are seen as instruments both of regulation and sanction in what Foucault (1988: 18) has called "truth games". Margaret Lock & Vinh-Kim Nguyen write in their book *An Anthropology of Biomedicine*:

> Biomedicine, despite its grounding in science, is a site of struggle about control and the interpretation of what will count as legitimate truth claims with respect to body classification and management. (Lock & Nguyen 2010: 82)

What counts as evidence and for what reasons a specific type of evidence is applied is thus a crucial and powerful question to ask (Engelke 2008: S5; Ecks 2008: S77ff), especially because evidence, quality control, and sanction of medical work are tightly linked. Even though no large-scale programs such as the one in the *NHS* exist (yet) in Switzerland, regulation through guideline adherence none the less takes place either in the form of health insurance companies' queries about specific treatments (s. section 5.2) or on a rather local level. In terms of the latter, a family physicians said:

> Of course there are moments of truth when you have removed yourself from something [guideline] and the person must enter the hospital. Where you have to explain why you did it that way. That is the kind of review board thing, where it decides if something is treated in a good or bad manner. Sometimes there are situations where you suddenly have to admit someone to – let's say – a mental institution. At times they [psychiatrics] perhaps ask themselves why the patient hasn't received antidepressants, and where one must explain the reasons for having done it differently [than required by the guidelines]. (Dr Kuhn)

Interestingly, the regulation of medical quality through adherence to guidelines also creates new room for agency. Despite family physicians' critique of definite guidelines as rules, they sometimes apply guidelines as strategic tools for explaining, legitimising or defending medical clinical decisions against other actors (patients, health insurance companies, lawyers and specialists). In such cases guidelines thus have a protective function against non-expert criticism or "malpractice cases" (Busch 2011: 103). "Hence", Busch (ibid.: 69) writes, "the employment of mechanical objectivity serves as a barrier to unwanted criticism". Yet, as one doctor commented critically, this practice might also lead to the point that physicians hide their decisions behind guidelines and thus refrain from responsibility:

> One can simply say that according to the guidelines it was not necessary to prescribe antibiotics to this man, and that one only did as the guidelines say. (Dr Tanner)

Guidelines thus have an orientating and supporting function in medical decision-making, as well as a legitimising, defending, and preventive function. One critic emphasises "that EBM gives too much power to health bureaucrats, hospital administrators, and insurance analysts" (Ecks 2008: S82), neglecting the fact that physicians have also begun using EBM as a legitimising tool for their clinical decisions and, in a broader sense, as part of a positioning strategy in the health-care system. EBM in these cases is applied as a specific resource to represent and realise professional interests. This performative use of the EBM terminology could be observed, for instance, in the early period following the foundation of the first university institutes of family medicine in Switzerland. At the foundation ceremony of the *Institute of family medicine* at the *University of Bern*, a professor of family medicine emphasised:

> […] in Switzerland no reliable data which legitimise our existence [family physicians] exist at the moment. This too is a challenge on which we must work.[137]

Apparently, this identified gap led to an increased use of scientific rhetorics. For instance, in their statements the Institute representatives chose a rhetorical strategy that circled around terms such as "there is evidence for…", "current data demonstrate…", "to prove with data…", "studies show…", and "is more effective than…". The argumentation strategy thus made use of a biomedical and health-economical rhetoric to promote the academisation as well as the general promotion of Swiss family medicine.

In reaction to the perceived hegemonical establishment of EBM, a great deal of work critical of EBM has been published since the 1990s, usually pointing out the incompatibility of guideline rationales with individual illness episodes, physicians' working realities and their caring for individual patients (e.g. Green & Britten 1998; Green & Ruff 2005; Kleinman 1995). Arthur Kleinman (1995: 29), for instance, crit-

[137] Thomas Rosemann, professor of family medicine at the foundation ceremony of the *Institute of family medicine in Bern (BIHAM)*, 1 April 2009 (author's translation).

icises "its [biomedicine's] discomfort with dialectical modes of thought". Biomedicine, as he continues, requires "that single causal chains must be used to specify pathogenesis in a language of structural flaws and mechanisms as the rationale for therapeutic efficacy" (ibid.).[138] Such a perspective implies that disease can be objectified and thus de-contextualised from patient and doctor. From this perspective, the course of a disease is clearly structured and predictable, and medical interventions are purely biological, wherein the "inherent logic is one of simplistic cause-and-effect: substance A will act on substrate B, causing effect C" (Wilson 2000: 204). Hence, EBM both produced and revived certain counter-discourses, such *as narrative-based medicine (NBM)* (Greenhalgh & Hurwitz 2005b; Charon 2001a; Mattingly & Garro 2000) or *complexity theory* (Topolski 2009; Martin & Sturmberg 2005; Miller et al. 1998). Charon (2001a: 83) explains medicine's increasing fascination with such complementary approaches as a reaction to the marketisation, "technologization" and "specialization" of medical practice.

Complexity theory, i.e., "deterministic chaos theory, nonlinear dynamics, and fractal processes" (Holm 2002: 78), is considered the latest cultural turn, evolving in the late 1990s (Urry 2005). Representatives who apply complexity-theory reasoning to health-care issues attempt to bridge social sciences with natural sciences and to claim the applicability of a systems approach to research on health care. In his manuscript *Understanding health from a complex systems perspective*, Stefan Topolski (2009: 751), for instance, calls for the enlargement of Engel's biopsychosocial health model with complexity theory in order to develop a "new health model" based on "six basic aspects of health" (physical, environmental, emotional, social, cognitive, semiotic) whose sum defines health (ibid.: 749).[139] Apart from these theoretical conceptualisa-

[138] This was written for instance in *A Textbook of Family Medicine*, where Ian McWhinney (1989: 46) states that "[t]he physician's main task is to diagnose the patient's disease and to describe a specific remedy aimed at removing the cause or relieving the symptoms. He or she uses the clinical method known as differential diagnosis. Diseases follow a defined clinical course, subject to medical interventions. The physician is usually a detached neutral observer, whose effectiveness is independent of gender or beliefs".

[139] Critical voices such as the physician and philosopher Søren Holm (2002) are hesitant about the innovative potential of these new approaches and doubt that complexity theory manages to solve the basic limitation of biomedical reasoning, namely the determinacy of things, i.e., the causal explana-

tions, "complexity" has become an increasingly used term among family physicians. My data collection showed that physicians' understanding of complexity is by no means always related to complexity theory, but for the most part is used rather colloquially as a notion for multi-layered, intertwined, and uncertain situations in medical practice. In my interviews complexity was defined in a threefold way. First, it was deployed as a term to describe the trajectory of clinical decision-making from the "raw material" (Dr Debrunner) to diagnosis and treatment. Second, it served as a term to navigate, translate and negotiate between professional networks, patients, and their families. And third, it was used to balance ethical questions such as: What is a good decision? For whom must it be a good decision? Physicians' quality perceptions were related to the handling of these and further complexities. In fall 2009 I noted:

Together with three family physicians I organised a conference workshop[140] *where the 120 international participants were asked to formulate their understanding of complexity. Complexity was defined by one of the groups as issues that are "interwoven with threads of many colours (many logics)". Among these threads participants listed a whole-patient-orientation (including a patient's inclusion in the context of clinical decisions), the negotiation of clinical questions with multiple actors (patients, their families, specialists), the handling of chronic diseases and multimorbidities, the communication between different parties, the unvoiced concerns of patients, information overflow with increasing uncertainties and limitations, time pressure and the priorisation of urgent matters, dealing with ethical questions in fields such as palliative care, dealing with personal (professional) limits and avoiding burn-outs, the different roles of physicians (e.g. psychologists) and technical challenges (e.g. electronic record keeping). To illustrate the mentioned complexities, we*

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tions of health and illness. Even though complexity science does not conceive life as something linear but, as the term suggests, as something complex, it still draws an image of a system in which all components influence each other, as the central notion „deterministic chaos" illustrates (ibid.: 79).

[140] Abraham, Andrea, Bruno Kissling, Sylviane Neuenschwander and Helen Hartmann 2009: How "soft facts" shape family medicine: reflecting on the blurred field of complexity. *Wonca* Europe Congress *The Fascination of Complexity – Dealing with Individuals in a Field of Uncertainty*, Basel, 16.-19.09.2009. For further information s. abstract book at http://www.smw.ch/docs/PdfContent/smw-12931.pdf (p. 148) or Abraham & Kissling (2011).

closed the workshop by laying the transparencies on top of another (s. figure 3). (Fieldnotes, 23 September 2009)

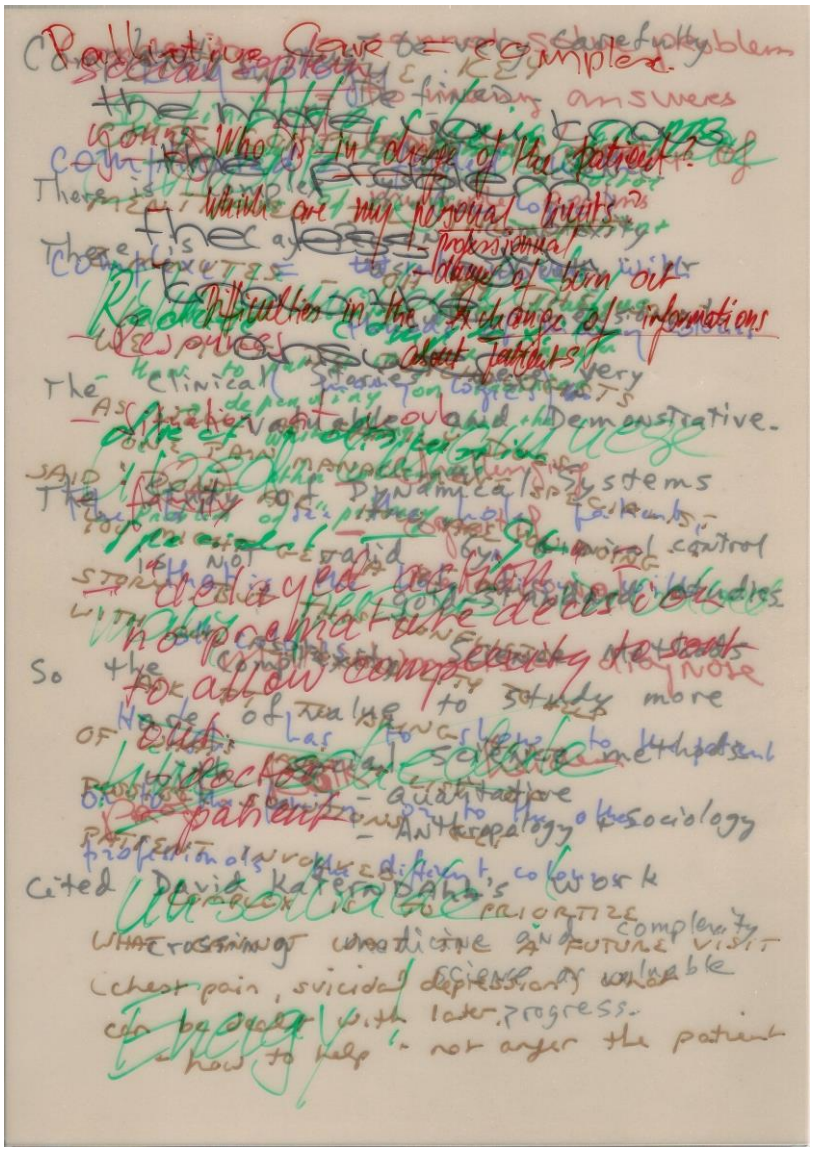

Figure 3: Image of clinical complexities as formulated by family physicians

These different epistemological approaches (here illustrated by way of complexity theory) that emerged out of EBM-critical discussions point to attempts to produce scientific knowledge in which professional realities are mirrored. In these realities the single actors (individual patients and physicians) are the main point of reference:

> Informed by such models as biopsychosocial medicine and patient-centered medicine to look broadly at the patient and the illness, narrative medicine provides the means to understand the personal connections between patient and

> physician, the meaning of medical practice for the individual physician, physicians' collective profession of their ideals, and medicine's discourse with the society it serves. (Charon 2001b: 1897f)

6.2 Patient-centeredness

Until the late 1970s the patient-doctor relationship was commonly conceptualised in a paternalistic way, namely as an uneven, asymmetric and hierarchical relationship. The American sociologist Talcott Parsons (1970: 20f), for example, described patients as non-responsible, helpless and unqualified to make the right medical decisions, and denied them the ability to judge physicians' work. From his perspective patients depend on physicians' assistance because they do not have the tools to make their own choices (ibid.: 19). However, since the emergence of patient support groups (Vogelsanger & Bickel 2004) and patient organisations (Kessler & Ziltener 2004) in the late 1970s, the autonomy of the medical profession started to be questioned increasingly in Switzerland. These organisations vouched for patients' rights, gave patients a voice and thus contributed strongly to the deconstruction of professional power. Ideas such as patient education, patient empowerment, patient satisfaction and patient safety were developed on this ground (ibid.: 209ff), and are framed by the term patient-centeredness. Two physicians illustrate this transformation as follows:

> There are the elderly people [patients] that are now dying or have already died. They had an ideal image of the doctor. They didn't ask anything but were glad and grateful, and appreciated me. And then a generation emerged who increasingly started to work out of town, who learnt new conventions, who made more demands either in terms of my time of attendance or in terms of referrals to specialists […]. Of course everything became more time-consuming. […] The demands increased. This led to an increased workload in the practice but also to more conflicts with the physician who was not willing to cooperate […]. (Dr Odermatt)

> Quality is missing when I need to be authoritarian, if I can't convince the patient by using explanations such as "you know, it's about this illness, I have used this instrument to verify it, and this is my therapeutic suggestion". However, something's wrong if I have to prove something by using authority. And that's some-

> thing which has changed radically. My predecessors could do it like that twenty years ago. They could say "You must swallow this". I cannot use the word "must" anymore. Nowadays it's about convincing [people]. The work with people has transformed greatly […]. If I need to say „you must do this", it lacks quality. (Dr Quinn)

These quotations show how the transformation of the doctor-patient relationship also changed physicians' definitions of quality: Medical quality is described as the antipode to professional authority. Apparently, quality emerges out of a collaboration and negotiation with and motivation of the patient. However, the levelling of the doctor-patient relationship, and consequently the transformation of medical autonomy that results from patient empowerment, and also therefore as a feature of medical quality, is, in practice, not simply "there" but rather a process of negotiation and ambivalence.

When the key components of medical quality are defined, patient centeredness is usually listed together with the terms EBM, cost-effectiveness or patient safety. Some actors consider it as a "primary quality dimension of its own" (Berwick 2009: w555) and thus consider it as a central feature of quality. The *IOM*'s (2001) famous report *Crossing the quality chasm: a new health system for the 21st century* called for health-care systems that respect patients' values, preferences and expressed needs; coordinate and integrate care across boundaries of the system; provide the information, communication and education that people need and want; and guarantee physical comfort, emotional support and the involvement of family and friends (ibid.: 52f). In contrast to EBM, patient-centeredness is a very open concept that is by no means operationalised in the same precise, narrow way. In his article *What "patient-centered" should mean: confessions of an extremist*, Donald M. Berwick (2009: w560) develops his definition of patient-centeredness from three "maxims", which include the priority of patients' needs, shared decision-making between patient and health professional, and the uniqueness of each patient. Against this background, he defines patient-centeredness as "[t]he experience (to the extent the informed, individual patient desires it) of transparency, individualization, recognition, respect, dignity, and choice in all matters, without exception, related to one's person, circumstances, and relationships in health care". Among the features of a patient-

centered approach, Steven C. Bergeson & John D. Dean (2006: 2848) list "access to and continuity with clinicians", "participation in care", "supporting patient self-management", "coordinating care among settings", and "address[ing] patients' needs and priorities". Apart from this, for the interviewed physicians in this study, working in a patient-centered manner implies the acquisition of contextual knowledge about patients to establish a common ground, to provide a locus of trust, to listen to patients and to enable them to talk openly. One physician explained:

> I define a good doctor in terms of the holistic nature [of his job] in the truest sense of the word. Holistic means that a doctor takes the patient seriously as a human being. This is meant in the sense of the biopsychosocial concept or the WHO definition and implies the inclusion of his social environment. (Dr Escher)

In this respect, patient-centered care implies that the physician takes on a role which the patient is comfortable with. This does not always imply shared-decision making, the credo of patient-centered care (Loewy 2005: 450). One family physician notes:

> Of course there are people who need guidance and others who can't stand it. There are people who need to be told "it goes like this", and they accept it as if I was their father. […] Still others can't stand it at all if you approach them like this. […] To some I don't appear authoritarian enough whereas others like it really well when they are offered two options. They need that. It really depends. […] Well, you might well tell them to do it either way, but they'll tell you that you don't even know it yourself. […] Yes, there exist different ideas. (Dr Berner)

Patient-centered care thus is oriented towards the patient's side, his background, preferences, likes and dislikes. It also implies full professional engagement instead of professional detachment (Berwick 2009: w562; Charon 2001b: 1899; Halpern 2001), a preference which automatically leads to a strong emphasis on the doctor-patient encounter as well as the professional's subjectivity. Rita Charon explains:

> When sociologists studied medicine in the 1960s, they observed physicians to practice medicine with 'detached concern.' […] Somehow, this field observation became a normative prescription, and physicians for decades seemed to consider detachment a goal. Today […] physicians are learning to practice medicine with not detached but engaged concern, an approach that requires disciplined and steady reflection on one's practice. (Charon 2001b: 1899)

This is a radical renunciation of earlier definitions, which considered emotional detachment as a feature of the medical professional (e.g. Parsons 1970: 14f; McWhinney 1989: 46). Yet, patient-centeredness implies a struggle about professional detachment. Emotional involvement – feelings, preferences, ambivalences, or rejections – remains an inherent aspect of medical work. Physicians are caught between professional objectivity and personal involvement. In this context physicians emphasised that they also have a "hidden agenda"[141] and often struggle with keeping a professional "neutrality" and emotional distance. They describe the emotional involvement as a continuum between sympathy/empathy and antipathy/aversion (Dr Christen), and as a constant negotiation between physicians and patients as roles and persons.

Different approaches have been developed that aim at conceptualising this specific understanding of professional involvement, among them NBM, which Charon has described as follows:

> Unlike its complement, logicoscientific knowledge, through which a detached and replaceable observer generates or comprehends replicable and generalizable notices, narrative knowledge leads to local and particular understandings about one situation by one participant or observer. […] Logicoscientific knowledge attempts to illuminate the universally true by transcending the particular; narrative knowledge attempts to illuminate the universally true by revealing the particular. (Charon 2001b: 1898)

From her point of view, "narrative competence" (as part of a patient-centered approach) bears the potential to improve care. She concludes her paper with the hypothesis "that the physician equipped with the narrative capacities […] can achieve more effective treatment than can the physician unequipped to do so" (ibid.: 1900). From this perspective patient-centeredness and patient satisfaction are seen as features of medical quality that complement quality aspects related to diagnostics and treatment in a stricter medical sense:

[141] A "hidden agenda" is a "non-declared agenda item", e.g. a "non-declared reason for a consultation" but also the doctor's unformulated hypotheses, reflections, and aims (Zimmerli et al. 2004: 197, author's translation).

> [I'm a good doctor] if I understand my patient. [If I understand] what he really wants. And sometimes this is not a lot, sometimes he really just wants to get his lungs auscultated. To be awake enough to realise what he wants, what he needs, if he needs something additional. (Dr Isler)

In this respect physicians emphasise that medical quality depends on the creation of a mutual "working hypothesis" (Dr Jakob) with their patients:

> Missing quality is grounded in the beginning of a conversation: For instance, with people who are mistrustful I sense from early on that it [consultation] won't be alright. A basic trust is needed for quality, and if it doesn't evolve, everything will be difficult. (Dr Quinn)

6.2.1 Dealing with particularities

In their work family physicians are confronted with specific patients and their social networks, with various living conditions and biographies, and with particular local environments: this "sociocentric orientation" (Kleinman 1995: 37) is considered to be one of the specialties of primary health-care providers. The narrative accounts of the physicians I interviewed and accompanied throughout the last few years were full of information and anecdotes about family structures, conflicts, workplace situations, biographies, living environments and cultural specificities. For example, a retired doctor who regularly fills in when his colleagues are on holidays explains:

> When I replace my colleague in the Canton of Uri, in the middle of nowhere, where it's mostly shady in winter, where it's raining a lot, where there are wonderful mountain landscapes, and so on and so forth: Not only is the clientele different, but there are also really different behaviour patterns and traditions […]. In the Canton of Wallis the loving God takes center stage, the black Madonna, about how death is predetermined. So again, I see something completely different. […] Or when I replace my colleague in the Zurich Oberland: People are emancipated, there are urban railways, shops all over, and so on. People here demand something really different. [Through these replacements] I learn about the incredible diversification of Switzerland, and that's the case all over the world. Well, I find this interesting. It requires a constantly varying medicine, a varying communication with people. (Dr Lehner)

Many of the patients dealt with by family physicians are patients they accompany through a certain illness or life episode. Due to the fact that they are usually con-

fronted with more than one kind of symptom or illness per patient, they get to know their patients in different illness contexts. The above quotation illustrates that "[t]he situations of practice are characterized by unique events" (Schön 1993: 16). The individual patient, the single case (Kirschner & Lachicotte 2001: 444f), thus represents the starting point in medical decision-making. As Muller (1999: 221) notes, "[t]he story of the individual patient – 'the case' – is still, despite the reliance of the medicine on scientific theory and generalizable results, an important mechanism for understanding how general scientific knowledge is applied to particular individuals". So, the process of clinical diagnoses and decision making is one where "problems […] must be constructed from the materials of problematic situations which are puzzling, troubling, and uncertain. In order to convert a problematic situation to a problem, a practitioner must do a certain kind of work" (Schön 1993: 40). It is thus the professionals' task to apply this knowledge in practice, so that "the real world of daily practice must be bridged, and new knowledge translated into practical applicability", as was written in an early article on quality in family medicine (Parry 1975: 555). „Knowledge alone", as the author of another such article notes, "is sterile. It is the use to which you put your knowledge that is important" (Jeffs 1973: 685). Being a medical professional thus means linking both scientific knowledge and experience with the individual patient, with "a need for case-by-case decision making" (Posner et al. 1995: 488).[142] The challenge of translating generalizable results into the individual case was well illustrated in one of the quality circle meetings where the prevalence of men who suffer from a prostate carcinoma and the clinical recommendations for PSA (prostate-specific antigen) screening were discussed: The point of departure for the discussion in the meeting was a recent recommendation published by the *Swiss Medial Board* (2011) which spoke out against standardised PSA screenings[143] of men without risk factors and symptoms, because these screenings apparently do not have a significant effect on the overall mortality and only a little effect on the

[142] However, I noticed in this realm that despite the emphasis on uniqueness and individual treatment, doctors create certain patient typologies (e.g. patients doing shift work, depressive patients) that assist them in "classifying" (Dr Notter) and "structuring" (Dr Lehner) certain symptoms, to evaluate the gravity of an illness, and to adapt medical talk, prescriptions and further treatment accordingly.

[143] The evaluation of the PSA level may help doctors to detect a prostate carcinoma at an early stage.

disease-specific mortality. The board's final recommendations thus say that it is not justifiable to test the PSA value for men without a risk disposition and without carcinoma symptoms. Consequently, PSA tests for this category of men should therefore not be reimbursed by the health insurance companies. These recommendations initiated a controversy within the group which was characterised by a general uncertainty about the practical implications of this recommendation. The reactions among the members (also visible in the letters to the editor of local newspapers and medical journals) were controversial. One doctor lamented that the controversy about the benefit of PSA tests takes place on the basis of statistical data. But he stressed that in the consultations with his patients he cannot invoke statistics: "We treat individual cases and not statistics!" That is why general recommendations such as the one above do not serve his direct contact with patients. Another doctor stated that he leaves the decision about whether to do a PSA test or to abstain from it to the patient. Still another physician did not agree at all, stressing that this decision needs to be made together with the patient in the sense of „shared-decision making", because there are no simple yes- or no-answers to this question. Another doctor added that in the context of such tests he often gets asked by patients if he would get the test done himself.

So in which cases does a family physician decide to define a patient as a patient at risk? When knowing that a certain percentage of an age group suffers from an illness, how does this knowledge affect physicians' decisions? In this respect I do not agree with Ecks (2008: S80), who assumes that with the increased use of EBM "[d]octors are trained to believe more in statistical evidence than in what they observe in clinical practice". Rather, physicians oscillate between the statistics and guidelines at hand, and their own perception of a specific situation. They thus trade off statistical significance against clinical and personal significance (Sweeney et al. 1998) in a dialectical way. In this process, additional forms of knowledge such as contextual or tacit knowledge are important, and will thus be discussed in the following pages.

6.2.2 The role of contextual knowledge for clinical decisions

Contextual knowledge is generally assumed to have a benefit both in anamnesis, diagnostics and treatment (Charon 2004: 862). Long-term doctor-patient relationships, understanding the patient's suffering from a biopsychosocial perspective, knowing about the patient's living and working conditions, about his emotions, fears, preferences and dislikes: All this is *per definitionem* included in family medicine as a medical discipline. Physicians' accumulated (and often non-formulated and thus implicit) knowledge about their patients is declared to be an indispensable basis of decision-making in family medicine (e.g. McDaniel & LeRoux 2007), which was acknowledged in early articles on quality in family medicine (e.g. Hadfield 1953: 685, 687). Schön (1993: viii) assumes "that competent practitioners usually know more than they can say. They exhibit a kind of knowing-in-practice, most of which is tacit". The tacit dimension (one doctor (Dr Gebhard) called it "off-records") is described as an inseparable part of professional practice. Schön (1993: 50) states that "[e]ven when he makes conscious use of research-based theories and techniques, he is dependent on tacit recognitions, judgments, and skillful performances". Physicians have told me that in many cases contextual knowledge increases the precision of a diagnosis, the estimation of a risk disposition (Dr Debrunner) or an emergency, the feasibility of a treatment plan or the appropriateness of a treatment:

> If I know the [patient's] environment and have accompanied him for a long time, I can decide in a different way than if I see someone just once in a while. How far should we go [with tests and therapies]? What's in the patient's interest? How must I evaluate his symptoms? All of that. […] To arrange and balance this. […] Yes, perhaps one might say it's like that: I'm more familiar with it. Perhaps one has a different basis for mutual trust when the family is known. It's just a very valuable basis. (Dr Jakob)

Accordingly, in cases where physicians do not know their patients precise and appropriate decisions are constructed in different ways. When physicians are on emergency duty or replacing colleagues who are on holidays, they tend to do more tests (e.g. laboratory) because they cannot compare patients' symptoms to their general well-being. A family physician illustrated this with the example of an ambulatory emergency service that treated one of his patients. The physicians working there had

to conduct various tests to diagnose an iron deficiency whereas the family physician (who was not on duty then) knew that the patient is a long-distance runner and has suffered from these symptoms before. Charon's work supports such statements. In one of her articles she even paints the picture that typically emerges in cases where contextual knowledge is absent, saying that consultations which pay no attention to the patient's context and perception might result in prolonged and thus more expensive diagnostic procedures and in poorly working doctor-patient relationships (Charon 2001b: 1899).

However, such pointed arguments run the risk of neglecting the ambivalences and difficulties that physicians possibly perceive when working with patients they are familiar with. Family physicians describe their social engagement with a patient as one that should not result in "ensnarement" (Dr Christen), "fraternisation" or a "lack of social distance" (Dr Jakob). They describe the ambivalence between closeness and distance, between empathy and detachment, between knowing the patient well and not knowing him/her, as a tightrope walk between "a huge benefit and a huge danger" (Dr Aeschbacher). The perceived danger refers to the risk of misinterpreting or ignoring symptoms due to the contextual knowledge a doctor has about the patient. Third-party knowledge (from other health professionals or the patient's social environment) is considered an additional constraint here. Patient information that family physicians learn through a third party, and which the physician cannot use transparently in the consultation, may not necessarily be an advantage but sometimes maybe perceived as a "huge bias" (Dr Sieber) and an interfering "hidden agenda" (Dr Gebhard). A doctor explains how the totality of received information grows into a jigsaw puzzle:

> You start collecting these puzzle pieces and suddenly end up with a possible picture. But it's a long journey until this picture proves true. Perhaps it turns out to be different, eventually. Then you need to be careful […]. (Dr Tanner)

Against this background physicians emphasise the importance of oscillating between closeness and distance. In fact, it was stated that not every treatment requires contextual knowledge, and that its necessity usually depends on the kind of suffering and

the type of patient. Physicians noted that treating rather unknown patients might even result in a "more neutral" situation which they perceive as valuable, too:

> [With unknown patients] I make use of my observations and my guidelines and out of this a quite different relationship develops, of course. A professionally more neutral, less emotional situation appears. Sometimes that's certainly not bad. (Dr Quinn)

This deep ambivalence between knowing the patient without getting too close to him is described as follows:

> On the one hand I find it interesting to learn new things about people. But the closer someone gets to me, the more difficult I find it to become free again. I need a certain distance to be able to do my work. I like doing home visits but here, too, or in a conversation, a certain distance is important. […] when I see such things [deprived living conditions during home visits] it weighs me down. When I work so much [70-90 hours a week] it's likely that there are certain things that I don't want to know exactly. […] It's not always a help to know more […]. (Dr Tanner)

Physicians listed many situations in which they felt uneasily close to their patients, for example when patients make them a gift, or when they wish to be on first-name terms with a physician, or discuss their suffering outside the consulting room, or ring the doctor's bell (in cases of non-emergencies) when he is not on duty or on vacation. Different strategies of regaining more privacy and distance were described: One doctor (Dr Christen) for example never asks her patients about their well-being when she meets them on the street. Physicians working and living in the same place expressed this need for privacy much more than those living in a separate place. One doctor (Dr Sieber) noted that he is glad that his car is parked in the garage so that patients cannot tell if he is at home. On his consultation-free days he usually works without light to avoid patients ringing his bell. Another doctor (Dr Notter) leaves the house through the backyard when going for his Sunday walk.

6.2.3 Intuition and experience

In early discussions on medical quality in Switzerland, it was criticised that the focus of quality programs falls solely on clinical knowledge, whereas the capacity of applying that knowledge, through the role of experience and intuition (used as syno-

nyms in the article), is completely neglected. In presenting his arguments, Johann Jakob (1988: 798) expresses his doubt that experience can be taught or even evaluated. This might be one explanation why in quality programs up to now, which have shifted their focus increasingly from core values to operationalisable aspects, intuition and experience have vanished or are even discussed as a barrier to providing medical quality (Choudhry et al. 2005). In relation to medicine's overall orientation towards statistics, Richard Horton noted:

> The quest to acquire meaningful data led medical scientists to develop quantitative methods for interpreting results in terms of averages (the true meaning of 'norm'). Advocates of this mathematical approach aimed to replace the intuitive judgements of physicians with sound statistical reasoning. (Horton 1995a: 317)

In an interview one doctor told me that he is really interested in the role of intuition for medical reasoning. When a local institute of family medicine launched a call for research ideas, he submitted this research idea, but received no response. Of course, that might be a coincidence. Yet, it could also be an expression of family medicine's collective attempt to support only those research projects that can be advertised as "real" science. This second assumption is supported by the fact that intuition in medical practice is only marginally researched (e.g. Langewitz 2006[144]; Stolper 2009; Andre et al. 2003) and that it "is not a topic with which a great research reputation can be established" (Dr Tanner), despite the importance assigned to it by family physicians in the interviews. In fact, to the interviewed physicians, intuition and gut feeling are "a huge issue" (Dr Isler). One doctor notes:

> I believe that this [intuition] is the decisive quality […] that defines the job as I perceive it. To me personally this is quite extreme. […] Sometimes I'm surprised myself about how many non-verbal – how shall I say – messages come in. […] I probably don't notice it anymore. (Dr Odermatt)

[144] Unpublished manuscript, download at http://www.unispital-basel.ch/das-universitaetsspital/bereiche/medizin/kliniken-institute-abteilungen/psychosomatik/abteilung/mitarbeitende/wolf-langewitz/ [19.03.2012].

But how is intuition defined? How do physicians understand it? The physicians I interviewed defined intuition as a "gut feeling", as something that "is in the air" (Dr Frei, Dr Christen). They explained:

> It's as if we absorbed it: how someone is dressed, how he smells, how he shakes hands, how he sits down, […] what his tone is like. […] That's one part of the psychostatus. (Dr Peters)

> It [intuition] is important. I can barely quantify it but it starts previous to the verbal communication: how the patient sits in the waiting room; how he enters, how he greets people, what he radiates or doesn't radiate. Already in the hallway to the consulting room I observe how he walks, how he sits down, and so on. This plays a major role. I attach value to intuition increasingly. (Dr Quinn)

> There are simply specific situations where one immediately senses that underneath the [tip of the] iceberg something's just not right and not the way one's used to. The more you have experienced this, the standard situations, the easier it gets to say that something isn't exactly the way it should be, even though you don't know exactly what's wrong. (Dr Tanner)

Intuition is thus not described as a free-floating, metaphysical aspect of decision making but firmly grounded on biomedical knowledge and circumstantial observation as part of clinical experience. Focusing on knowledge only is, as one doctor noted, "like an alpinist who only exercises but who doesn't ever go mountain-climbing". He continues by saying that „you have to know and practice a lot first before you can rely on intuition" (Dr Tanner). Physicians explained that intuitive decisions relate past situations with present ones (Dr Quinn, Dr Odermatt):

> I don't believe that intuition springs up out of nothing. It develops from an influential experience. […] And as time goes by it [intuition] becomes sharpened, refined. But I don't believe that intuition is pure talent. […] It gets processed, worked out. (Dr Quinn)

So physicians stress that intuition is not just there, but that it is learnt and acquired over the years of training and practice. This means, in turn, that in the early years of practice physicians have to substitute for the lack of intuition:

> Back then [at the beginning of practising] I had to secure much more often with technology, with blood tests, with X-rays. And now only after a few years [of practice] I need much less technology. (Dr Quinn)

In this respect, Schön (1993: 138) talks about a "repertoire" that any practitioner relies on, which "includes the whole of his experience". Experience, intuition, and knowledge are thus interrelated (Salzberg 1987: 102). In their research about the determinants of gut feeling, Eric Stolper et al. (2009: 7), for instance, distinguish between two different types of gut feelings, "a sense of reassurance and a sense of alarm". In terms of the latter, physicians in my research group noted that there are cases which do not point to something serious at first sight but which they still want to refer for further examination. In a quality circle meeting it was agreed that laboratory results are not the only basis for decisions, but that sometimes intuition is even more important. Interestingly, it was also stated that numeric analytical results, for instance, can also prompt intuitively triggered medical reasoning to go further: They help the doctor to develop "a certain feeling" for evaluating a situation. As Stolper et al. (2009: 7) write, "[a] sense of alarm means that a GP has the feeling that something is wrong even though objective arguments are lacking". Such a case was described in a case narrative written by a family physician (Dr Tanner):

> In 1989 my sister died at the age of 37 of a pulmonary embolism, after various physicians in the ambulatory sector (family physician, emergency doctor, alternative practitioner) couldn't make a correct diagnosis ("influenza", "psychosocial stress") during two weeks. I studied [medicine] in my 5th semester and was not informed about my sister's illness (and also not capable of diagnosing it). Her death hit me. I'm probably still trying to overcome it. I've tried, first as a hospital doctor and during ten years as a family physician, to pay special attention to pulmonary embolism (still a difficult diagnosis yet one that has become easier)…
>
> A 20-year-old patient visits me with cough and sputum production as well as shortness of breath over four days. The anamnesis and physical examination indicate an infected exacerbated asthmatic bronchitis […]. The laboratory test confirms the infection […], the lung function confirms the obstruction. The chest X-ray is normal. Two days later, after a therapy corresponding to the diagnosis […] the patient is doing significantly better, subjectively as well as objectively […]. In two days a consultation is arranged to assess her incapacity for work […].
>
> Two days later I pick up the phone myself—unusual for me—due to the workload of my medical practice assistant […]. It is the aforesaid patient, out of breath, who wishes to postpone the visit for two days, due to an important talk with her boss. Her shortage of breath concerns me but she affirms that she only

> ran up the stairs, and that she's really doing well. She doesn't want to come to the clinic today and it's impossible to convince her that this might be important. I give her the new appointment as desired. But the rapid breathing that I heard on the phone keeps bothering me. In the afternoon I hear my medical practice assistant talking on the phone with my patient's father, who orders his pain killers from us […]. I step to the phone, take it from my assistant and ask the father (ignoring medical confidentiality) if his daughter still lives at home and how she's doing. He answers that she lives next door and that she's doing well, but that he will check after the phone call. Ten minutes after the conversation the father enters the practice with his grown-up daughter in his arms. She's completely blue […] and first, I think that she's dead. My blood is curdling. The father has found his daughter alive yet severely shocked and hypoxemic […] in her apartment and brought her here without thinking (which was probably, again, very dangerous). We provide her with emergency medical aid (suspicion of pulmonary embolism) until the ambulance takes her. Afterwards it turned out that she had a severe central pulmonary embolism.

So in the interviews it became clear that intuition is like a track switch that assists the doctor in selecting further steps and interventions, such as tests, referrals or hospitalisations (Dr Odermatt, Dr Notter). As with the statements about the role of contextual knowledge in section 6.2.2, so also here: in this respect physicians point out the double role played by intuition. Besides the notable benefits coming from the intuitive sensing of crucial emergency aid, as above, they have also noted that intuition may be accompanied by several drawbacks, such as a biased examination (Dr Lehner), premature decisions (Dr Sieber), the incapacity to formulate intuitive decisions to patients, colleagues, or health insurance companies (Dr Odermatt, Dr Frei), or the comparison of unequal situations (Dr Tanner) to each other.

6.3 Negotiating spheres of autonomy and competence

Despite their apparently contradictory characteristics, evidence and patient-centeredness do not seem to me to be two concurring approaches but rather, broadly speaking, two poles in the continuum of medical decision-making: Evidence represents the scientifically produced knowledge base, whereas patient-centeredness is about concrete human beings, about illness and disease in a particular sense, and

hence about the application of scientific knowledge to the individual case. Family physicians – and probably other physicians and health professionals as well – resort to a pluralistic and applied understanding of evidence (Engelke 2008: S15) based on EBM but by no means restricted to it. Hence, guidelines in medical practice are accompanied by alternative or additional reflections. One interviewed doctor described this fittingly by using the image of a table:

> Well, to me this [medicine] is like a table, you know. Evidence-based medicine is a table leg. I can't imagine having a table without this table leg. But it's simply not the only or most important one. There are a lot of table legs. And if I would want to apply all these (EBM) guidelines I couldn't work anymore, because my patients would have to take so many drugs and have to come for so many examinations. But I must know these guidelines. (Dr Tanner)

Another doctor used the allegory of a puzzle:

> Guidelines define a special field. Apart from it, further special fields exist. The puzzle of these fields eventually go into the making of a good doctor. It's not the guidelines alone which define a good family physician, but perhaps it's a question of definition. […] For instance, a carpenter may be a good carpenter even though he works in a less exact manner when it comes to zinc coating. It's the same way with a family physician. (Dr Escher)

In their work physicians thus constantly move back and forth along an epistemological continuum rather than simply applying scientifically-grounded knowledge to a particular patient. The relationship between the two poles – the medical standard and the individual patient – is thus a dialectical one, an "as well as" relationship rather than an "either/or" one. From this perspective medical decision-making implies both „analytic" and „valuational" reasoning (Cassell 1984: 40ff) and thus is located in a field of tension between theory and practice, objectivity and subjectivity (Rychner 2006: 21), between a „logico-scientific mode" and a „narrative mode of knowing" (Czarniawska 2004: 7). When making decisions physicians enter a dialectic trajectory rather than focusing either on science or on the individual case. In doing so they oscillate between rationalistic approaches such as the Bayes' theorem, tacit approaches such as intuition, and patient-centered applications thereof (Greenhalgh 2007: 115ff). By going through these movements additional types of knowing and evidence – tacit and contextual knowledge, experience, and intuition, knowledge

transfer and exchange among colleagues, and entrepreneurial considerations – form an integral part of medical decision-making (Green & Britten 1998; Barbour 2000; Portwich 2005). The process of knowledge acquisition and application is thus to be imagined as a social construction and negotiation (Gabbay & Le May 2004). This construction of medical decisions happens through the oscillation between different kinds of knowledge and interactions, which form an epistemological corpus, or to use Donald Schön's (1993) term, an "epistemology of practice". As Kurtz (2002: 59, author's translation, emphasis in original) has emphasised, professional knowledge means more than the sum of different forms of knowledge but is a "competence *sui generis*".

However, the intertwining of both a very specific and narrow concept (evidence), and a concept that is hard to define and, consequently, difficult to operationalise (patient-centeredness), poses a central contradiction in the current quality dispositive. When evidence and patient-centeredness are simultaneously declared to be quality criteria, this opens up a series of questions, such as: How are scientific knowledge and the individual patient related? Which one is the main point of reference? Is „good" care or „best practice" an inductive or deductive procedure? And, importantly in this context: How wide is the radius of patient-centeredness, meaning: Where does the patient "start" and where does he "end"? How is a patient defined?

Berwick (2009: w555), certainly one of the most radical representatives of a patient-centered approach, argues for a "consumerist" transformation of the locus of control from caregivers to care-receivers. This implies a redefinition of "professionalism"[145], respectively the neoliberal construction of the instance "patient" so that it is not physicians but patients who define what quality of care is about (ibid.: w557; Sklair 2001: 116). Berwick states:

> In [Eliot] Freidson's world of professions, excellence is in the eye of the professional. In the more normal world of products and services, excellence is in the eye of the customer. The latter is not a moral position; it is a pragmatic one. The

[145] Here, Berwick (2009: w557) refers to Eliot Freidson's definition of professionalism, which implies the professional self-definition of quality, physicians' status of medical experts, and the idea of professional self-regulation.

> business theory underlying modern quality strategies is that producers that meet consumers' needs, as judged by consumers, will thrive, and those that do not will wither. (Berwick 2009: w558)

In this respect evaluations of patient satisfaction are considered a form of how quality assurance might take place (Heje et al. 2007).[146] One doctor expressed her dissatisfaction about being assigned the full responsibility for medical quality:

> To me it's almost painful that quality is mainly requested from us physicians, but not also from the patients, in a way. If you analyse a large company you check how the bosses behave, how the employees work, and how the product looks in the end. […] And in our quality and efficiency discussions it's hardly ever checked if patients are satisfied, and what patients' consumption and behaviour look like. (Dr Quinn)

In the context of making decisions on a continuum between clinical guidelines and patient-centered criteria, the physicians who were interviewed stated that at times this customer mentality conflicts with their own quality ideals. Thus family physicians apparently find themselves in an area of conflict which is determined by their own quality definitions, the claims of patients and external quality requirements. Loewy (2005: 451) emphasised "that patients are not the property of the physician but neither are physicians mere vending machines who must act against what they think is medically advisable". For instance, one doctor explained that although he considers his patients as customers and his practice a service centre, the treatment needs to be in line with his clinical and ethical principles. He stated that strongly demanding patients make it impossible "to practice medicine reasonably" (Dr Notter). So for physicians difficulties start to emerge when there is no mutual "working hypothesis", as I have mentioned earlier. Such conflicts might result in claims for specific forms of examination (physical examination, auscultation, "objective" la-

[146] Such evaluations are conducted in HMO practices that undergo a quality certification procedure, such as the one offered by EQUAM, for example. In HMO group practices evaluations of patient satisfaction are an inherent part of the practice's quality management. In this respect, doctors complain that they are evaluated in an anonymous way, which makes it impossible for them to understand the context in which criticism is raised. Context is thus stripped from the single case. Internet platforms are an extreme form of this, where single doctors can be rated in total anonymity. The first one in Switzerland was the website of *okdoc – quality improvement* (www.okdoc.ch [20.11.2011]), which was installed in 2008.

boratory tests), referrals for further tests and examinations, or specific medication ("real" drugs such as antibiotics) (s. also Domenighetti & Pipitone 2002; Nichter 2008: 97).

When physicians feel under pressure by patients who request specific diagnostic or therapeutic trajectories, physicians react in different ways. Sometimes they give in (to prevent patients from "doctor shopping"), sometimes they stage professional authority, in other cases they negotiate with their patients and formulate their discontent or, in extreme cases, reject patients or terminate conflict-laden relationships. One doctor explained the handling of such conflicting situations as a feature of medical quality:

> To talk about it [conflicts] may mean that a patient gets severely displeased, but I've raised the issue all the same. If I do that, I'm a good doctor. Therein, there's even room for a conflict with a patient. (Dr Aeschbacher)

This chapter has shown that the epistemological discourses which run through the quality dispositive negotiate the definition of illness, disease, and most adequate treatments. These definitions are followed by quite different types of knowledge (reaching from "closed" types such as EBM to "open" ones such as intuition) and differing methodological processes of knowledge production. However, these discourses reach beyond definitions and methodologies. They transform former roles and thus create a new social milieu in which care takes place: physicians are no longer considered as the only experts of medical issues but have to negotiate about "best treatment" choices with additional professional actors and patients. These negotiations thus alter the professional boundaries and spheres of competence and authority of family medicine.

Doctor Quinn | Working with marginalised patients

Dr Quinn is 42 years old, married, has two children and lives and works in a suburban community. She has a great passion for medicine in general. The reason that she chose to become a family doctors lays in her private life: it is a specialisation which allows part time work.

She works part time in a group practice with two male colleagues who will soon be retired. One of them is specialised in handicapped patients, the other one in sports medicine. Dr Quinn perceives the difference in age as a true advantage because she profits from her colleagues' long lasting clinical experience. A further advantage is the sharing of costs, a challenge, however, the communication flow: most of the time Dr Quinn and her colleagues are busy organising their staff and the clinical procedures.

She has a heterogeneous range of patients. However, she is specialised in patients suffering from HIV/AIDS, drug addicts and illegal immigrants. The former are very expensive patients. That is why Dr Quinn has much higher expenses than her colleagues which will eventually result in a cost-effectiveness proceeding as she fears. The outcome of this procedure will decide on her professional future: if she will not be able to explain the reasons for her high expenses to the insurance services, she will quit her job.

Dr Quinn has developed a special way of dealing with those patients who cannot afford to pay for her services: they help out in her garden or her house. However, she does not describe herself as a good businesswoman. She would prefer to receive a monthly salary as it is the case in the British health care system.

Dr Quinn is member of a quality circle of doctors all specialised in HIV/AIDS patients. Additionally, she regularly visits a quality circle of family doctors who work in the same geographical area. She benefits a lot from both quality circles and their exchange of professional experience on a democratic, unforced level. Additionally, she would like to participate in a Balint group but postpones this activity to a period when her children will be older. As an alternative, however, she visits a psychotherapist on a regular basis to discuss particular cases and her own well-being.

Doctor Ruch | Woman power and family medicine

Dr Ruch is in her forties, married to a priest and mother of two small boys. She runs a single urban practice and works part time. She is member of a physician network which obliges her to participate in a quality circle. However, she feels very critical about those quality circles which do not serve the purpose of exchange, knowledge transfer and reflection but which are rather used to show off. In such settings she loves to be provocative and to affront her counterpart. The second quality circle which she still visits consists of a very heterogeneous group of doctors who Dr Ruch feels comfortable with.

Before her professional independence Dr Ruch was employed in a small rural practice. She liked the broadness of her job and did everything from putting broken arms and legs in a cast to stitching up wounds or diagnosing atrial fibrillations. Dr Ruch's medical education first led her to psychiatry. However, after the suicide of her sister she chose the field of family medicine even though the broad knowledge and skills which this field requires scared her. After working in an African country for one year she completed her medical education in several smaller hospitals in the fields of surgery and internal medicine. Parallel to the completion of her education she got pregnant with her first child. Her husband looked after the baby during the first year after birth so that she could complete her education. She remembers this period as traumatic (long working shifts, short-handed teams, hierarchical structures, lacking understanding for working mothers). She then worked part time and substituted for different family doctors. During this time her husband completed his studies in theology and started to work as a priest. After eight years of part time work in the rural practice, where she had a very low salary, she decided to become independent and opened up her own practice which is located on the same floor with other doctors who all work independently. Even though she has worked in teams for many years, she enjoys her single practice a lot. Dr Ruch works part time (60%) and has a very heterogeneous clientele, ranging from drug addicts, patients with a mental handicap to patients living in homes for the elderly. Beside her job Dr Ruch is active in the fields of medical education, humanitarian aid, and writes for a medical journal.

Doctor Sieber | Being a family doctor for the rural population

Dr Sieber has a single practice in a small rural village where he has lived and worked for the past nine years. The interior of her consultation room is kept very simple. He does not even have a computer in this room anymore because he does not want the doctor-patient encounter to be distracted in any way. He underwent his medical training in rather small and less specialised hospitals where he was confronted with a broad array of symptoms and illnesses. In his practice, most of his patients are farmers and come to see him for rather serious illnesses and symptoms which keep them from working. Dr Sieber is very careful with psychosomatic issues because many of his patients still have different ideas about the origins of their suffering. Due to the small size of the community and the strong social ties of its citizens, Dr Sieber often receives information about a particular patient from third-party sources. At times this creates a certain bias which he feels ambivalent about. He is member of a Balint group because he perceives the patients he considers as "difficult" – healthy patients who believe to be sick – to be a professional challenge he wants to discuss among peers.

As a young doctor, Dr Sieber used to work in African countries where he adopted a certain professional coolness in cases of emergency. Back in Switzerland, he went through mountain rescue training and worked for an organisation which does emergency medical assistance by air. That is why he does not get stressed easily when he is confronted with emergency cases.

Looking back, Dr Sieber regrets that he chose to live and work in the same village due to the difficulties to separate private life and work. There are always some patients who do not respect his opening hours.

Dr Sieber does not know what the future will bring. His colleague who works nearby will soon be retired and has not yet found a successor for his practice. He is afraid that his own workload will increase dramatically when his colleague's practice will be closed. He is really concerned about his workload and its effect on his health. Whereas in the past he had a reasonable salary which compensated for his workload, his salary has decreased continuously.

> There is a set of expectations surrounding health and the body prevailing in western societies: we expect to feel well, without pain or disability, long after middle-age, we expect all children to survive birth and infancy, all women to give birth with no complications, all surgery and medical treatment to be successful. And for the majority of individuals, these expectations are indeed met, serving to reinforce them even more strongly. However, although medical authority may confer an image of reassuring competence and control of the situation, the construction of the medical practitioner as omnipotent inevitably leads to disappointment and disillusionment when things go wrong, resulting sometimes in legal actions against doctors. When the unexpected happens […] there are few explanations that can provide meaning to the experience. Furthermore, while we continue to look to medicine to provide help when we are ill, we also express resentment at the feelings of powerlessness we experience in the medical encounter. (Lupton 1994: 1f)

7 Patient safety and medical misconduct

7.1 Global quality discourse on patient safety

The patient-safety discourse started to emerge out of a general Western orientation towards safety and security (Power 2007; Holert 2004), paired with the emergence of patient organisations, which provide patients with new possibilities to stand up for their rights, to rate and benchmark physicians on the internet or to open legal pro-

ceedings against physicians.[147] In his book *Organized uncertainty. Designing a world of risk management* Michael Power (2007: 4) states that this orientation "can be understood as an 'audit explosion' […] in new clothing, a new mode of accountability and monitoring in the name of risk". He analyses how this new focus on risk and risk management has spread out globally and entered different fields, institutions and governments. He describes how the management of risk is aimed at through specific practices and normative instruments, such as scientific guidelines and standards which ought to create "ideal frames" to manage uncertainty (ibid.: 6). These instruments derive largely from the anticipation that risk can be controlled. So, to avoid the entrance into "zones and circulations of insecurity" the focus constantly falls on participation in the "security collective" (Holert 2004: 250, author's translation). This demands an organisation and institutionalisation of risk management which Power explains as follows:

> These visions of "risk" manageability also constitute a new space of responsibility and actionability. It will be argued [in this book] that the organization of uncertainty in the form of risk management designs and standards is related to expectations of governance and demands for defendable, auditable process. (Power 2007: 6)

According to Bröckling[148] (2004b: 212, author's translation), prevention is a "risk technology" because it aims at reducing risk, here in terms of medical errors and uncertainties[149], through safety programs. Prevention therefore targets people's behaviour and its improvement. It thus functions through "socio-regulatory" (Holert 2004: 247, author's translation) mechanisms that are repressive as well as productive:

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[147] Power (2007: 2) notes that the „expansion in discourses of risk and its management" was expressed, for instance, by the emergence "of numerous practitioner magazines with the word 'risk' in their titles". Examples from health care are in this respect *Health, Risk & Society*, *Journal of Healthcare Risk Management*, or *Clinical Risk*.

[148] Bröckling discusses the preventive approach in the sense of prevention from illness and promotion of health. However, I find his reflections very helpful in reflecting on the preventive aim of patient safety.

[149] Authors distinguish between errors, critical incidents, adverse incidents and adverse events. Given my own working parameters, in this chapter I will not always manage to draw a clear distinction between these different categories of misconduct.

> Prevention sanctions and rewards, threatens and encourages, scares off and instructs, collects and singles out, withdraws resources and assigns them, installs technical control systems and uses social networks. (Bröckling 2004b: 210, author's translation)

To set up such regulatory systems, patient-safety programs build, amongst other things, upon safety concepts from industry. In the preface to the *IOM* report *To err is human. Building a safer health system*,[150] it is stated that "there is a sizable body of knowledge and very successful experiences in other industries to draw upon in tackling the safety problems of the health care industry" (Kohn et al. 2000: x). In the aviation industry, the onset of pilot-error analysis awoke medicine's interest in such handlings from the mid-1960s on, resulting in different safety and error-handling concepts, among them *critical incident reporting systems (CIRS)* and *quality circles* (Wilf-Miron et al. 2003; Chattopadhyay 2003), which will be discussed later in this chapter.

Patient safety, looked at from a preventive stance, builds on a paradoxical conceptualisation of subjects: On the one hand, in the sense of de-subjectification – i.e., it regards the subject as an arrangement of different risk factors that need to be controlled and minimised – and on the other hand it views the subject as a "self-responsible and competent actor of his own life" (Bröckling 2004b: 214, author's translation). Transferred to medical conduct, this means that the focus rests on medical performance, particularly the following of set-up standards and guidelines (de-subjectification). On the other hand, physicians are urged to assure the quality of their performance, to continuously reflect on it and to change their behaviour (self-responsibility).

Since the early 21st century, discussions on patient safety have become a major discourse in the quality dispositive. In this respect, patient safety is regarded a "critical component of quality" (Kohn et al. 2000: 18). It represents one of the three features

[150] This was the first *IOM* report of a large project called *Quality of health care in America*, followed by the report *Crossing the quality chasm: a new health system for the 21st century* (Institute of medicine (IOM) 2001).

that the *IOM* considers as dimensions of medical quality.[151] The onset of patient-safety discussions represents an attempt to establish the discourse on medical fallibility that was long hindered by a "culture of infallibility in health care" (Manser & Staender 2005: 3). The *IOM* considers "medical errors" as one constraint on quality of care that, "if discussed at all, is discussed only behind closed doors". It thus intends to break down "[t]raditional clinical boundaries and a culture of blame" (Kohn et al. 2000: ix). In this respect Albert W. Wu notes:

> Strangely, there is no place for mistakes in modern medicine. Society has entrusted physicians with the burden of understanding and dealing with illness. Although it is often said that "doctors are only human," technological wonders, the apparent precision of laboratory tests, and innovations that present tangible images of illness have in fact created an expectation of perfection. (Wu 2000: 726)

Thus only since the late 1990s have the risks of medical misconduct for patient safety been regarded as issues that need to be discussed in public (Beyer et al. 2003b: 327; Huber 2002: 1517) and thereby changed from being "a policy of silence" (Stoellger 2005: 980, author's translation), that is, from an issue that is "repressed" (Willimann 2003: 762, author's translation) to one discussed in public by different actor groups.

Patient-safety discussions are intended to replace this negative-error culture with an approach that acknowledges errors as an inherent and not fully avoidable reality of medical practice (Schwappach & Boluarte 2008; Schwappach & Koeck 2004; Wu 2000; Chattopadhyay 2003). This aim builds on the acknowledgement of health care as one of the most insecure of fields.[152] In this respect an author describes family medicine as "a field with a high risk of errors" (Willimann 2003: 762, author's translation). The interviewed physicians typically have stated that in cases where physicians do not have a lot of "objective information" about a patient's suffering (Dr Notter), risk becomes an inseparable aspect of care (Dr Sieber, s. also Willimann

[151] The other two dimensions, knowledge/evidence and customization, were discussed in chapter 6 under the notions of evidence-based medicine and patient centeredness.

[152] For instance, in his set up of risk categories, Chattopadhyay (2003: 18) classifies health care as highly risky, placing it in the same category with mountain climbing and bungee jumping.

2003: 763). Against this background the aim of patient-safety discourses is to accept medical errors as an inherent aspect of medical practice, to learn from them and to find ways to prevent them. Wu explains:

> Physicians will always make mistakes. The decisive factor will be how we handle them. Patient safety and physician welfare will be well served if we can be more honest about our mistakes to our patients, our colleagues, and ourselves. (Wu 2000: 727)

For many years political and research agendas have focused on errors in inpatient care but not on ambulatory primary health care (Beyer et al. 2003b: 328). A large international survey on failure in family medicine has tried to change this limitation by investigating failures in this setting. The survey's research design was based on asking general practitioners the following questions (ibid., author's translation): "What has happened? What was the result? What might have led to the mistake? How could the mistake have been avoided?" So, discussions on medical fallibility have led to attempts to examine situations in which mistakes happen, and on possibilities for reducing or preventing them.

7.2 Risk reduction and prevention

Despite the emphasis placed on medical fallibility and the urgency to de-stigmatise medical errors, it remains the aim of patient safety to reduce them to the minimum through preventive programs. Representatives of patient-safety discussions urge action to prevent medical errors which, as they stress, not only harm patients but are also related to high extra costs. Hence, along with the preventive, pro-active approach goes the "promise" for cost-containment (Bröckling 2004b: 214, author's translation). Medical errors are viewed, in this respect, as having an epidemic character that must be made transparent if it is to be reduced. In the last book before his death, Donabedian (2003: xxix) wrote that "[b]ad practice by some encourages bad practice by others". This is used as a major legitimising argument for quality monitoring, but it also, at the same time, stands diametrically opposed to reflections by family physicians on misconduct. One physician explains his position:

> There are rascals. But if there are two or five percent bad physicians, it remains questionable if the [whole] health care system is bad. How many of these bad physicians can we bear? Must we be compared to these five percent who fuck up, who profiteer, who want to "take it easy"? (Dr Gebhard)

As Bröckling (2004b: 211) explains, the preventive approach is based on a rationale of future-directed probability that needs to be calculated and minimised. This approach is not something unfamiliar to family physicians in their daily decision-making. One interview partner illustrates the clinical calculation of risk by way of the example from mountaineering, a sport to which he is deeply dedicated:

> There exist models to evaluate the danger of an avalanche locally. And this is a model which I can somehow translate to my work. Where I can say that either many aspects come together which might create a dangerous situation, or only few aspects come together which might create a dangerous situation. (Dr Tanner)

Even so, continuing with his comparisons between medical work and mountaineering, he emphasised that he manages this process of balancing risk factors against each other through an oscillation between medical knowledge, experience and intuition. In his critical discussion of preventive approaches Bröckling (2004b: 211, author's translation) remarks that it is usually impossible to reduce „biological processes, human behaviour and […] social phenomena" to "clear-cut cause-effect correlations". As a consequence, „preventive knowledge always remains incomplete", calling for additional research (ibid.) that aims at enhancing predictabilities (Jenkins et al. 2005: 15). Yet, the pro-active strategy that preventive programs are based on does not ensure "secured quality" but rather puts "quality under suspicion" (Stoellger 2005: 981, author's translation).

The aim of prevention is behaviour change, that is, the alteration and standardization of individual routines (Bröckling 2004b: 212). One doctor who works in an HMO practice where "failure management" is an inherent part of "quality management" illustrates the establishment of such preventive standardisations by way of the example of communication procedures among staff members:

> [The instruction to the medical practice assistant is handled] in written form so that no errors happen. Everything in a specific order, we must do it that way. I

> can't just run into the laboratory and say "Test this [patient's] blood" but I fill in a standard form. […] I only have to mark with a cross without writing anything else. And I've got everything in electronic form, too, so that we won't lose anything. In that way we could reconstruct it [treatment]. (Dr Peters)

None the less, the claim for behaviour change also produces critical voices and counter narratives (Bröckling 2004b: 212). In his reflection on standardised communication patterns and their integrated safety loops, one family physician working in a rural practice complains:

> The short, direct ways, the personal experiences [get lost]. […] Statistics were developed, they were also published, that show how much we save through shortcuts, through a concise and restrictive information flow. [In the past] a phone call [to my colleague in the hospital sufficed]: "Can you have a look at this [patient]? When can he come to you?". [He would answer:] "Right now." because he knows that I probably made a correct diagnosis and that it doesn't make sense to conduct further examinations. Today, unfortunately, first he has to sign a form, for legal reasons. In the past I would have said: "Listen, when can he come to see you?". [Colleague:] "I'll do a quick endoscopy tonight." And the next day the farmer could go back home and milk his cows. That's all gone and doesn't interest anyone anymore. What counts is that the guidelines are adhered to, that quality is assured, that everything is documented and that heads roll. I tell people: „Look, today the only thing that counts is what can be punched or saved on a disc. Everything else, forget it, it doesn't count anymore." (Dr Odermatt)

7.3 Trajectories of medical errors

Despite the fact that authors estimate a high number of "reported incidents and near misses" (Bate & Robert 2007: 6) and iatrogenic[153] cases of death (Kohn et al. 2000) in Western health-care systems, it is difficult to give reliable information about the prevalence of medical errors and critical incidents (Chattopadhyay 2003: 18), not least due to the problem of under-reporting and the difficulty of defining whether something is an error or not. Nevertheless, experts assume that "[m]edical errors are

[153] Iatrogenic is usually used in a negative sense to depict complications "induced in a patient by a physician's activity, manner, or therapy" (http://www.thefreedictionary.com/iatrogenic [02.01.2012]).

among the most serious quality problems in health care systems and are associated with considerable health-related harm and economic burden […]" (Schwappach & Koeck 2004: 317). The literature and studies on patient safety place a strong emphasis on this economic aspect of failures and critical incidents, that is, on the "follow-up costs [such as] extension of hospital stay, remaining morbidity, reduced capacity to work, [and] liability" (Kaufmann et al. 2002: 2554, author's translation) that accumulate after such an event.

Errors, critical incidents and near-misses are all plotted on a continuum whose perceived severity and meaning varies according to the different relations an actor has to that incident. Furthermore, not all errors are recognised immediately, because they are often embedded in clinical routines (Wu 2000: 726). In cases where physicians are not aware of having made a mistake, they rely either on the patient signalling it to them or on their professional environment telling them. In the interviews it was noted that the forms in which patients do this vary, from telling the physician directly or complaining about the physician to changing physicians. Errors therefore cannot be easily categorised. In this respect Bosk (2003: 23f) states that "[m]edical decision making is a probabilistic enterprise" and criticises the "unequivocal ontological status" given to errors. He stresses that the definition of an error depends on a "set of background understandings, norms, and values" (ibid.: 24). Having said this, I will now turn to trajectories of incidents that physicians define as being either critical or errors. In this respect I will stick to human errors made by physicians,[154] and I will distinguish between four fields where they may occur, namely in diagnostics, therapy, communication and organisation (Huber 2002: 1518, based on Wilson & Sheikh 2002).

7.3.1 Diagnostics

During diagnostic procedures errors may happen, for example, when the symptoms are misjudged and the problem thus has been inappropriately defined, when the chosen differential diagnosis is wrong or too narrow, when facts and test results are ei-

[154] Studies have shown that human errors are among the most common type of errors (Lang & Kissling 2001: 90).

ther missing or misinterpreted, or when referrals are delayed (Huber 2002: 1518; Lang & Kissling 2001: 90). In his reflection about such situations a doctor thus states:

> I'm not a good doctor if I don't detect the problem and it's only found out in the hospital. (Dr Notter)

Another doctor remembers her first day of replacing a colleague in a rural practice which ended one week later with a tragic incident:

> A patient came to the clinic [with chest pain], 38 years old, smoker, two packs a day […]. I examined him, made an ECG, got laboratory tests done and a chest X-ray […]. During the examination he seemed to feel sensitive on a rib. Obviously he had taken nitroglycerin before, but it didn't help. […] he came back after one week […]. The ECG was good, the chest X-ray was good. I had been afraid that he might be suffering from a tumor. […] In fact, the laboratory [tests] were good too. I believed that it [pain] could rather come from the muscles or the skeleton. On [the following] Monday we got a phone call [from the patient's office]: "Mister O. is hyperventilating again, can we bring him in?" […] [After they got here] the medical practice assistant ran into my room, screaming: "You must come, you must come!" He had stopped functioning. […] Of course we immediately called the ambulance. They arrived here quite quickly, but he had stopped functioning. Later I learnt […] that on Saturday he had helped his parents-in-law move. Afterwards he suddenly felt a pressure [in his chest] and they called the ambulance. They [ambulance staff] supposed that he hyperventilated and gave him a bag [to breath into] whereupon he felt better. He got up, went to have a smoke on the balcony, and the ambulance left without him. That was on Saturday, and on Monday he [hyperventilated in his office and was brought here by his colleagues]. They performed an autopsy on him [in the hospital]. You know, we had tried to resuscitate him for three quarters of an hour outside of my practice […]. It was so horrible that it still gives me the creeps. He was so young, he had two small children. When they had brought him to the hospital his pupils still reacted to light. That means that we did a good resuscitation job. […] a little bit of oxygen still made it to his brain. [But] he died. It was so horrible for me. On the one hand his age. […] And then this feeling of powerlessness. And then of course the question how I will tell it to my boss. […] I sent the ECG to the hospital because they were interested in it. Well, you couldn't anticipate it based [on the ECG]. (Dr Ruch)

In other cases the diagnostic suppositions and self-diagnoses of patients or their relatives may have a misleading effect. In collecting critical incidents during a quality circle meeting, one doctor recalled a learning-disabled patient whom he often treated for clinical bagatelles. Suspecting a depression due to relationship problems, his caregivers took him to the doctor. The doctor remembers that the patient looked bad and coughed. He conducted a chest x-ray, rather *pro forma*, and was surprised to diagnose an aspirated foreign body which led to an atelectatis in the right inferior lobe. A bronchoscopy led to the healing of the „depression", as he noted ironically.

7.3.2 Therapy

Studies have found a wide range of reasons for therapeutic errors. In the case of drug therapies physicians have told me about wrong dosages of drugs (s. also Huber 2002: 1518), ignorance about drug interactions, confusion among drug names (e.g., *Clarithromycin*® instead of *Claritin*®, *Fraxiforte*® instead of *Fraxiparin*®[155]), wrong applications of drugs (e.g. intramuscular instead of subcutaneous injection), double prescriptions of drugs or missing follow-ups (e.g. lack of complete information about patients who are treated on emergency duty), or patients' confusion about their medication. I was told a case where the methadone for a couple was prescribed ten times too high. Fortunately, the couple noticed the wrong prescription and didn't swallow a much higher dose than usual. Instead, they sold the rest of the methadone on the street and told the doctor only months later, due to their guilty conscience.

7.3.3 Communication

Studies have located the reason for the greatest number of medical mistakes in the field of operational collaboration between the actors involved in care processes. These errors typically involve difficulties in coordination. Among them are missing or erroneous exchanges of information (Huber 2002: 1518), teamwork difficulties

[155] The *Swissmedic* institute estimates that in Switzerland this type of medication error is responsible for around 100 deaths annually. *Swissmedic* and *Stiftung Patientensicherheit* (*English* Foundation for patient safety) both work to change the marketing and design of certain pharmaceutical products, and to replace the names of pharmaceuticals that sound alike yet have different effects. They have encountered resistance, however, from pharmaceutical stakeholders, who argue that due to the international pharmaceutics market such local adaptations are not feasible (Brotschi 2012).

and the lack of clarity about responsibility among staff members (Beyer et al. 2003b: 330). In this last respect, one doctor told me about an error that involved a colleague in his group practice:

> It was "ping-pong" between an emergency unit and our practice. The patient went back and forth from the emergency unit to our practice. She was here three times and in the emergency unit two times. When she was here for the third time, the doctor thought that she couldn't be suffering from anything serious because she had also been to the emergency unit where they had examined her too. *De facto*, a few hours after the third consultation she [was here again and] dropped dead due to a cerebral haemorrhage. That's why she had suffered from a headache. The other team didn't recognise it either, but my colleague was of course the last one who treated her. (Dr Debrunner)

Still other reasons are located in those patient-doctor relationships that physicians perceive as being difficult (Beyer et al. 2003b; Lang & Kissling 2001: 90). One interview partner saw this as one of the major risks for error that affects her practice. Describing a missing connection to a patient, she states:

> In such cases errors happen again and again. In terms of diagnostics, or when I write a prescription, or when he doesn't take the drugs correctly due to misunderstandings. (Dr Quinn)

7.3.4 Organisation

A fourth possible source of errors is located in the organisation of practices and care institutions. Among the difficulties in this sector is, for example, a lack of adequate planning, especially when it allows too many patients coming in as emergencies. So, as Lang & Kissling (2001: 90, author's translation) note, factors such as "pressure of time, distraction and goal conflicts through parallel burdens and … [sic!] fatigue" contribute to the error-proneness of medical work. One doctor described such situations:

> It's often too hectic: too many patients, too many emergencies, no sound planning. The shortcomings and misunderstandings are rooted here. […] We've got such a high standard in medicine that there's no lack of means, but basically it's communication. Or a lack of further check-ups because we are too hectic and have too much work. (Dr Quinn)

7.3.5 Border zones of misconduct

Not all doctor errors are manifest slip-ups or critical incidents in the sense that they can be spotted and analysed. This further range of errors belongs to what I call "border zones of misconduct", to situations, for instance, where physicians are unable to reach, convince, or understand patients, or where they set priorities that do not correspond to the ones held by patients. Reflecting on an HIV patient who committed suicide the previous year, one interview partner explains:

> To me that's still somehow a failure because I didn't sense, didn't see that they were on the ropes. […] One of them was a handicapped woman living at the margin of society. I treated her at home. […] It was a tightrope walk with this drug addict: It was something very beautiful, it went well. She had an HIV infection which she always treated very seriously. And she was in a wheel chair, paralyzed due to an abscess in her spine […]. But she continued to live. The care was so well established that we decided on trying to treat the hepatitis C [which she suffered from too]. That means another year of therapy with interferon, a hammer blow. […] She had to get a liver biopsy done in the hospital, and during the biopsy her dog was run over. The dog meant everything to her, she didn't have parents. After she got home from the hospital […] she swallowed all the drugs that she had from me, injected the methadone, everything that she had in stock. She died of it at home at the age of 36 because her dog had died. This illustrates the limits of medical performance. It went well on a social level, on a technical level, on the level of ultra-modern therapy but failed because her dog was run over. That's almost ironic, but it clearly shows where the limits lie. For this patient I had spent an entire weekend at a hepatitis C training, and in the end didn't realise that her whole social situation was based on one single thing: her dog. (Dr Quinn)

This quotation illustrates the difficulty that physicians have in trading off different kinds of significance against each other, specifically here in terms of clinical against social ones. Although technically speaking this case was not handled incorrectly and thus would not appear in a list of clinical failures, the doctor still experiences feelings of failure and guilt. This fact has implications for the processes that follow a critical incident or error. As I will show, physicians require failure management approaches that are not anonymous and detached from context, but personal and specific instead. Furthermore, the stated examples indicate that failures happen at "break-

ing points" (Berchtold 2007: 317, author's translation) or transitional hand-offs between different actors. These breaking points are not necessarily clinically determined, but instead point to situations in which clarity is either absent or taken for granted, understandings diverge, and pressure tips the scales.

7.4 Forms of error regulation and handling

7.4.1 Open disclosure

Open disclosure was established as a pro-active "state of art" in cases of medical misconduct, not least to avoid time-consuming and costly court cases (Kraman & Hamm 1999: 966). This practice is thus taught in CME programs, as one doctor recalls (Dr Jakob). The interviewed family physicians stated that they often choose the strategy of open disclosure in cases of obvious misconduct (s. also Manser & Staender 2005: 1). This implies an honest, rapid communication with the patient, a strategy that someone called "flight forward" (Dr Ruch). The reasons for this are not only the hoped-for avoidance of a lawsuit or a bad reputation but also the re-establishment of the potentially shattered relationship to the patient. In their literature review Schwappach & Koeck note:

> We also provide further evidence that full disclosure of errors may strengthen rather than undermine the relationship between patients and physicians […]. In particular, in errors with moderate negative outcomes, the honest approach to the mistake actually decreases the likelihood of the patient reporting the error and the desire to punish the involved professional. (Schwappach & Koeck 2004: 322)

In this respect one family physician emphasised that patients are very tolerant about errors as long as the physician informs them and apologises for what has happened (Dr Jakob, s. also Wu 2000: 727). He reflects on his imagined behaviour if he were to commit a severe error:

> I would go for complete openness. […] To apologise immediately. […] I would immediately approach the patients by saying: "Listen, this has happened. We won't conceal anything now. I've already contacted my insurance company. We'll look for a mediator. Get in touch with a patients organisation." To open up

> completely. First, because it's fair. Second, because resentments grow and accusations are made if the physician doesn't apologise, hides and freezes out the patient. […] I would aim at finding an extrajudicial solution with the patient. […] In that way I believe that a lot can be salvaged. […] It's always best to express one's apologies, to admit that something didn't turn out well, and that I didn't perform well. (Dr Jakob)

In contrast to these strategies of family physicians working in independent settings, HMO practices work with a "conflict management" team that guides the physician through situations of misconduct, and both mediates communication to the patient and defines an ideal way of communicating (Schwappach 2010: 223). This strategy builds on the credo that patients' complaints are to be taken seriously, no matter what they are about. An HMO physician emphasises:

> Most importantly, patients' complaints must be taken seriously. In any case. One ought not to say "That's impossible" or "Why don't you leave". That would result in a huge uproar and a really bad reputation. (Dr Peters)

7.4.2 CIRS – Critical Incident Reporting System

CIRS is a computer-based reporting system that has its roots in the aviation industry.[156] In the Swiss health-care system, anesthesiology was the first medical setting which implemented this system, in 1995 (Kaufmann et al. 2002: 2554; Staender et al. 1997). A few years later, triggered by the global discourse on patient safety and further influenced by two medical errors that had been made public, the *FMH* initiated public discussions on this issue. A special taskforce called *Towards a safe healthcare system: proposal for a national programme on patient safety improvement for Switzerland* was set up, and communicated its future focus on critical-incidents reporting systems in 2001. CIRS was enlarged to other medical disciplines from 2002 onwards. It is considered as an instrument committed to continuous improvement which should contribute to a safe health-care system (Kaufmann et al. 2002: 2554; Huber 2002: 1520).

[156] The *Aviation Safety Reporting System (ASRS)* is a platform for "voluntarily submitted aviation safety incident/situation reports from pilots, controllers, and others". It "collects, analyzes, and responds" to these reports "in order to lessen the likelihood of aviation accidents" (http://asrs.arc.nasa.gov/overview/summary.html [02.01.2012]).

The *FMH* aimed at institutionalising a new, positive "error culture" (Lang & Kissling 2001: 93, author's translation) by establishing *CIRSmedical*. In this respect, Willimann (2003: 763, author's translation) refers to a "paradigm change" taking place in the management of medical errors, which accepts medical fallibility while at the same time trying to reduce it (Chattopadhyay 2003: 19). CIRS thus aims at moving from a "culture of blame" to a "culture of safety" (Huber 2002: 1517, author's translation). CIRSmedical is defined as a "bottom-up" instrument of "self-control". The FMH president hoped that CIRSmedical, as a "central aspect of quality assurance", will eventually form "the basis of a new credibility of the medical fraternity vis-à-vis society" (Kissling 2002: 236, author's translation).

In CIRS critical incidents are reported in an anonymous, largely de-contextualised, and closed way. Due to the Swiss law which sanctions cases of critical incidents that are made public, an error-reporting system works only in an anonymous way (ibid.: 234). It is emphasised that non-sanctionability is the prerequisite for physicians' reportings, and that the system assists them in getting rid of their feelings of guilt, thereby contributing to a critical self-reflection on the performed error (Huber 2002: 1520). CIRS thus constructs a space immune from prosecution which its supporters consider as the prerequisite of its functioning (Lang & Kissling 2001: 90). This anonymised reporting does not target single actors for blame, but aims at improving the systems in which such incidents happen (Kaufmann et al. 2002: 2554). It aims at teaching actors from various backgrounds and working environments about the prevention of errors and the improvement of working processes. Supporters of CIRS emphasise that this approach is more helpful than conventional error statistics because it equips professionals and their institutions with a sensibility for the causalities upon which an error is based (Stoellger 2005: 980; Lang & Kissling 2001: 90), and thus functions as a „learning system" (Kissling 2002: 235, Manser & Staender 2005: 5, author's translation): With the knowledge gained through CIRS, the primary actors strive to reorganise working structures and processes and thus to proactively enhance patient safety (Kaufmann et al. 2002: 2557).

So, against this background we may now place the main focus of these quality and safety discussions on two aspects: First, on the promotion of error discourse, that is,

the discussion of errors and fallibility, making it an issue. And second, on creating a culture of safety and prevention rather than a culture of blame, moving the spotlight from the individual physician to the system in which he or she works. These recent approaches that deal with mistakes have moved away from the individual "question of guilt" to "structural and organisational questions of causality" (Lang & Kissling 2001: 89, author's translation). Nevertheless, as opposed to this emphasis put on systems rather than single staff members or physicians, the fact remains that everything that follows from an error is very personal, reaching from individual feelings of guilt and shame (Schwappach 2010: 223) to disclosing and communicating the error to patients and colleagues. So, in contrast to the anonymity emphasised by CIRS procedures, the individual handling of errors is, in fact, very much about personal, social exchange, as I will show in the following sections.

7.4.3 Local and non-anonymous handling of medical errors

More than thirty years ago the medical sociologist Charles L. Bosk (1979) wrote an ethnographic study called *Forgive and remember. Managing medical failure*, which deals with critical incidents in an American hospital's surgery department. In the 2003 re-print of this book Bosk, while critically analysing the limitations and drawbacks of his earlier writing, also tried to point out its continuing relevance in the context of current patient safety discussions:

> The report [IOM report of 1999] finds that adverse events are not caused by individual negligence but rather by systems of care that pay too little attention to patient safety. […] *Forgive and Remember* suggests that errors are not events that can be simply counted. Instead, their existence needs to be debated; the discourse over precisely what is and is not an error is necessary to the formation of a sense of professional responsibility. What constitutes an error is an extreme example of "local knowledge". If attempts to reduce error are to be successful, they must grapple with how workers define error, understand its causes, and think it may be remedied. Policy makers also need to appreciate the constraints that workers labor under in order to formulate recommendations that workers will comply with rather than evade. (Bosk 2003: xxiii, italics in original)

Bosk's main points here – local and individual definitions of errors, and the working conditions related to errors – will be emphasised throughout the following sections,

which deal with family physicians' local appropriations and negotiations of regulatory programs such as CIRS or quality circles.

In order to look at local applications of CIRS, we have to take one step back, namely, to the moment after an incident occurs and before it is reported or discussed. In this liminal phase between occurrence and disclosure emotional distress may play a crucial role, not only for patients but also for physicians. Family physicians noted that in cases of error they "feel guilty" (Dr Christen), "ashamed", "stressed", "not well at all" (Dr Ruch), or "shocked" (Dr Quinn). Literature on the impact of errors on physicians' work considers the physicians' emotional distress after an error has occurred as a risk factor for future errors. In this respect authors talk about a "reciprocal cycle" (Schwappach & Hochreutener 2008: 1404, author's translation). Based on their systematic literature review, Schwappach & Boluarte (2008: 9) state "that involvement in errors often results in serious health effects, emotional distress, as well as performance and work-related consequences in staff members, in particular physicians". In this respect they refer to Wu's (2000) application of the notion "second victim" that "describes physicians' considerable emotional reactions and often long lasting distress in the aftermath of error" (Schwappach & Boluarte 2008: 9), that is "self-doubt, confusion, fear, remorse, guilt, feelings of failure and depression, anger, shame and inadequacy", "anxiety about future errors", "loss of confidence", "sleeping difficulties" or "reduced job satisfaction" (ibid.: 10f). Although family physicians have told me that emotions related to past errors keep influencing their work, it was not necessarily in a negative way but rather in the sense of "catalysts for reflection" (van Woerkom 2010: 348) as the two following quotations indicate:

> Memories [about past errors] that evolve, associations and perhaps emotions which were related to it [past errors]. […] If one did something wrong once… You might not have taken seriously a heart attack and the patient collapses with ventricular fibrillation from which you cannot save him. Afterwards, you send every patient who feels a pinch here [chest] to the emergency unit. Such things. These are professional variables on which one must work so that one is able to interpret the symptom without clapping on some nonsense onto the patient. It could be something exaggerated. But this matter [of associations] also contains a positive function as correctives if one doesn't manage to evaluate correctly later on. (Dr Frei)

> I learn most when I've missed something, when I didn't immediately discover something, or where something went wrong. I can transfer, translate something from these patterns. […] It hurts but one learns from emotionally strong incidents. (Dr Quinn)

It is stressed in the literature that only when the emotional part of the medical error has been dealt with and shared with others can physicians "approach the mistake with a problem solving focus, to explore what could have been done differently, and what changes can be made at the individual and institution level to prevent recurrence" (Wu 2000: 727). This factor is mirrored in family physicians' reflections on the communication and reporting of critical incidents. They express their need for a place where they can talk and reflect about their mistakes, but CIRS does not meet that need, as one doctor explains:

> Things like these critical incident centers are difficult. As we've said before, it [handling of errors] is strongly related to mutual trust [among colleagues], to the admitting of unfortunately really not being perfect, and to the outlook on how to manage the situation. (Dr Christen)

As physicians explained, this reprocessing is often done in social exchange with colleagues, either on a very informal and colloquial level, in more formal ways (quality circle and Balint group), or as part of an organisation's structure (s. also Schwappach & Boluarte 2008: 13). Wu perceives such social forms of dealing with errors as being constructive:

> While there is a norm of not criticising, […] reassurance from colleagues is often grudging or qualified. One reason may be that learning of the failings of others allows physicians to divest their own past errors among the group, making them feel less exposed. […] It has been suggested that the only way to face the guilt after a serious error is through confession, restitution, and absolution. (Wu 2000: 726f)

Although none of the interviewed physicians described CIRS in its original form as truly helpful, they adapted it to their local practice settings and constellations. HMO practices, for instance, have established CIRS as an inherent part of their systematic quality management (Huber 2002: 1518). An HMO doctor explained how, in case of an error, the reporting takes place, and that such situations are highly sensitive:

> […] we've introduced this principle [CIRS] two, three years ago and try to follow it after an incident. We have regular team meetings, at least one hour per week. If something happens it can be discussed there right away. This was the case two, three times already. I think that it's something very good. […] CIRS aims at checking how to disseminate the information so that everyone learns of it, so that it won't happen to them, and to adapt the system accordingly. So that it's not the failure of a single person but a failure within the system. In those two, three times where we've experienced near misses we've really profited from CIRS. But it's also something very hot, very delicate. Initially, I wanted to do it with an [external] supervision, especially if it would concern me. But after something has happened it [handling] must proceed quickly, without too much delay, it must be looked at right afterwards. At the moment it's me who moderates [the group] after something has happened. But in the two cases people were glad that it proceeded in this manner and that we could talk about it. Of course, it's always a challenge to break through the defensive wall but I think that we could profit from it. (Dr Debrunner)

Another doctor working in an HMO practice explains the structured steps that follow an incident:

> We've got the so called „critical incidents boards", and that's something incredible, of course. That's really confidential, we do it among the colleagues of the quality circle. We arrange seating in a different way than usual, so that we sit in a circle, as in a Balint group. It sometimes really reaches to the bones: Have I prescribed a wrong medication? Have I injected a wrong ampule? What can I do to avoid it in the future? Have I overlooked a fact? (Dr Peters)

Also some non-HMO quality circles, which consist of physicians from different practices who generally meet once a month, have included the reporting of critical incidents in their meetings (Stockmeyer 2008: 103). Yet, these handlings are usually less formal. In the quality circle I attended, one of the physicians suggested complementing critical incident reporting with some "superb cases" that they can learn from. This "positive incident reporting" (Stockmeyer 2008) may include cases such as the successful solution of a doctor-patient conflict, correct diagnosis of unclear symptoms, or detection of severe illness behind trivial-looking symptoms. After a few sessions where the reporting of incidents was treated as an issue in its own right, it melted into the current topics discussed. Family physicians told me that in daily practice, where they work on their own, they are still influenced by this kind of re-

flection on critical incidents. In describing her reaction after learning about a mistake, one doctor states:

> That's usually a shock, yet followed by something important: I try to use a few minutes to reflect: Where have I missed a step or where did a consideration not work? Or where did the communication fail? (Dr Quinn)

Family doctors consider processes of reflection about their own working patterns and clinical decisions as a crucial component of medical quality. Quality circles are institutionalised structures in which professional reflection takes place.

7.5 Quality circles

Professional self-reflection forms an often mentioned concept in discussions on medical quality. Gillie Bolton (2010: xix, emphasis in original), a British social anthropologist and representative of the *Medical humanities* defines reflective practice as "paying critical attention to the practical values and theories which inform everyday actions, by examining practice reflectively and reflexively". "Reflection", as Bolton continues, "is an in-depth consideration of events or situations: the people involved, what they experience, and how they felt about it", including "diverse points of view". To be reflexive implies „to find a way of standing outside the self to examine, for example, how seemingly unwittingly we are involved in creating social or professional structures counter to our espoused values. It enables becoming aware of the limits of our knowledge, of how our own behaviour is complicit in forming organisational practices […]. Reflexivity uses such strategies as internal dialogue to make aspects of the self strange. It requires being able to stay with personal uncertainty, critically informed curiosity, and flexibility to find ways of changing deeply held ways of being: a complex, highly responsible social and political activity".

Family physicians emphasised the importance that peer-group exchange has for their professional self-reflection, be it among practice partners, in the form of practice visits or in institutionalised forms such as quality circles or Balint groups. Among the benefits which the physicians name are the objectification of a case (getting support in gaining distance on the story), the feedback of colleagues (getting an external per-

spective on a specific issue), comparing one's work to that of others, learning how others work, getting inspiration and accumulating new knowledge, discussing uncertainty and failures and getting emotional support ("mental hygiene" (Dr Hauser)).

7.5.1 Bottom-up strategy

There is a fascination for cyclical learning and improvement models in various fields, such as the PDSA[157] cycle in industry (Deming 1986), quality circle (originally in industry, adopted by medicine), or the ALACT[158] model (Korthagen & Kessels 1999) in teacher education. All of them aim at initiating a reflective process and developing practices that should eventually lead to changing procedures or professional behaviour, be it in the field of industry, teaching, or health care. As I have noted in the introduction, quality circles, developed in the Japanese car industry,[159] represent a social practice through which the modern quality rationale has been circulating around the world and has become established in fields such as medicine (Sklair 2001: 115).

The first medical quality circles were established in The Netherlands in 1979 (Contencin et al. 2006; Beyer et al. 2003a).[160] Quality circles are, as opposed to less formal peer-review groups, described as being "part of a wider, more formal quality improvement program" developed and promoted strongly in Europe through the "world-renowned primary care quality guru" Richard Grol and his colleagues (Greenhalgh 2007: 287). He "has identified reflective practice (via quality circles or otherwise) and peer review as two key approaches for improving quality in primary care" (ibid.). Accordingly, quality circles are generally represented as a concept grown bottom-up rather than externally imposed on family physicians. They are thus

[157] Standing for "Plan, Do, Study, Act" also known as the "Deming cycle".
[158] Standing for "Action, Looking back on the action, Awareness of essential aspects, Creating alternative methods of action, Trial".
[159] *Toyota Motor Corporation* enhanced its productivity after World War II and developed the successful "Toyota Production System", which built on terms such as "lean production", "just-in-time manufacturing", "best practice", and "quality circles" (Mouradian 2002: 85; Sklair 2001: 115), all of which remain crucial until today.
[160] In the 1990s Germany integrated medical quality circles into professional activities and developed the first moderator trainings. In 2003 Switzerland was listed among the countries "with high activity" in this field (Beyer et al. 2003a: 445).

considered as attempts from within family medicine, employed not least of all as a proactive strategy in the shifting of professional boundaries. In 1995 Swiss authors formulate this pointedly:

> It is to be expected that quality assurance is an issue which nobody can avoid in the long run. Yet it now depends on "who" will decide in the future "what" is understood as quality in medical work and "if", especially "when" and "how", accordant evidence must be produced. Medical quality circles provide the unique, possibly the last, chance to answer this question on a voluntary basis, intra-professionally and outside of practice ("bottom up"). As long as resident physicians do not tackle this task themselves, solving it from the perspective of their daily practice concerns, then they must face the likelihood that cost bearers or the legislature will impose standards and enforce them in the framework of bureaucratic controls ("top down"). (Gerlach et al. 1995: 1120, author's translation)

7.5.2 Principles, structures and aims

Quality circles are defined as "small groups of physicians[161] (or interdisciplinary groups with other health professionals), based on voluntary participation and concerned with activities aimed at assessing and continuously improving the quality of patient care" (Beyer et al. 2003a: 444). The authors (ibid.) refine this definition by means of three core features that consider quality circles as:

- "continuing peer groups of GPs (or interdisciplinary) that meet on a regular basis,
- and aim at assessment and improvement of quality of care in different ways, e.g. by audit, guideline setting or adaptation, critically discussing personal medical practice, making plans for change,
- and which are autonomous (not mandatory as a form of external quality control)."

Quality circle meetings are moderated and minuted. The role of the moderator is described as encouraging the participant physicians "to improve their performance" and "maintaining early enthusiasm and quality of assessment" (Contencin et al. 2006: 70). The moderator thus leads the meetings, but he also has an impact on the perspective from which medical topics chosen by the participants are approached. For instance, during the first two years of my quality-circle participation, the group

[161] The quality circle I attended consists on average of 15 members (14 family physicians specializing in various medical fields, and a youth psychiatrist), which the group defined as the maximum.

was strongly fascinated by approaches such as NBM, systems theory and complexity theory. With the new moderator, a member of the quality circle, the meetings increasingly dealt with topics such as vitamin D prescription, borreliosis treatment or PSA screening. Interestingly, despite the fact that topics seemed to be more biomedical or clinical now, former ways of reflection remained a crucial way of approaching these topics.

Originally, quality circles were conceptualised as voluntary but continuous meetings. It was argued that only voluntary participation would motivate participants to critically reflect on their own work and on that of their colleagues (Gerlach et al. 1995: 1118). However, in Switzerland there is a partial transformation from classifying quality circles as "formal-internal" meetings to "formal-external" (s. Bosk 2003: 18f) ones, i.e., this voluntary precondition has changed into mandatory participation in some cases. In HMO practices, for example, quality circle meetings form an integral part of the practice's quality management. In physician networks, too, the participation in quality circle meetings is a requirement for the membership in the network. All family physicians belonging to such a network are required to participate in a quality circle at least eight times per year (Bally et al. 2009). Apart from these specific practice settings, the membership in a quality circle is part of CME (Contencin et al. 2006: 69f; Mäkelä et al. 2001: 53).

Quality circles are based on a systematic audit approach, i.e., the meetings are supposed to follow a specific cyclic structure (analysis, goal setting, realisation and evaluation) (Bally et al. 2009: 30; Gerlach et al. 1995: 1118; Mäkelä et al. 2001: 52).

> One of the central concepts in quality improvement is cyclical change. Having gone through the exercise of analysing and changing your own work, you know much more about it and often are eager to start the improvement process over again. Evaluation and revaluation are at the core of quality improvement. Each team that takes on quality work finds the cycle for itself and reaches its own understanding of how to organise topic selection, data collection, evaluation and change. (Mäkelä et al. 2001: 51)

In the past, Swiss quality circles aimed for measurable behaviour change. However, due to the difficulty of realising such measurements, this strict procedure was in-

creasingly abandoned and used only as a rough orientation for the discussion of clinical topics (Bally et al. 2009: 301). In an E-mail exchange about the future topics of the quality circle, one member emphasised the relevance of these cyclic procedures:

> I'd be interested in a long-term [quality circle] project […]. Although single topics are interesting too, we keep staying on the surface and don't tap the full potential of our experience. I'm particularly interested in the circular reasoning, that is, how we implement our elaboration in medical practice. How does change happen in respect to our perspective, to our agency, to the relationship to the patient? What are the barriers?

7.5.3 Constructing applied knowledge

Quality circle meetings attempt to overcome the evidence/practice gap and learn how evidence can be applied to practice (taking into consideration the specific local conditions), and also how practice in turn may produce new types of knowledge. In doing this, the shared knowledge comes in various narrative forms, reaching from clinical guidelines to case narratives, experiential accounts and summaries from visited continuous education workshops or conferences. Trisha Greenhalgh, a well-known representative of the NBM approach, considers the sharing of stories in groups as a form of "social learning":

> The experiential learning cycle […] does not progress solely by individual accumulation of new facts and experiences but by the construction of these facts and experiences into meaningful stories and the sharing of these stories with other individuals who are seen as homophilous (i.e. "someone like me, facing the same problems as me") and hence worth listening to. In a learning group […] learners' stories are the vehicle through which the meaning of a shared or common experience is negotiated and reframed. (Greenhalgh 2007: 288)

Biomedical issues are discussed in the quality circle meetings against the background of medical practice and physicians' experience but also against bioethical or health-political discussions. Hence, the approach towards biomedical topics is always practice- and experience-oriented, that is biomedical topics are contextualised, interpreted, explained, and worked on with regards to medical practice, local working conditions and the concrete range of experience the participants bring along (Gerlach et al. 1995: 1118). In their ethnographic study on physicians' "knowledge management", Gabbay & Le May ((2004: 1013) show that the interviewed GPs bare-

ly ever looked up specific guidelines but chose different, often parallel and less formal ways to acquire EBM knowledge: Through newsletters from GP magazines and through discussions with their professional networks, with the latter representing the most important way to acquire knowledge. The authors call these alternative, multifaceted forms of knowledge acquisition "mindlines", i.e., "collectively reinforced, internalised tacit guidelines, which were informed by brief reading, but mainly by their interactions with each other and with opinion leaders, patients, and pharmaceutical representatives and by other sources of largely tacit knowledge that built on their early training and their own and their colleagues' experience" (ibid.: 3; s. also Charon 2001b: 1900). This is illustrated on the following fieldnotes:

When discussing the meeting's main topic, PSA screening, one of the physicians raises the issue of the upper age limit of PSA tests by asking questions such as: "How reasonable is it to even diagnose and treat a prostate carcinoma in an 80-year-old patient?" or "After which age does one stop with PSA tests?". All physicians agreed not to evaluate the PSA value of elderly patients. In this context the physician who initiated the discussion tells the group about a case which troubles him. He would like to hear his colleagues' opinions and recommendations about the following situation: His patient is 87 years old, free of pain and fit. He describes his patient as independent and decisive, which is expressed, for instance, through the annual laboratory testing that he has done independently by the physician. In the last test his PSE values were strongly enhanced, which brought him to the physician. Due to these values and further examinations the physician is certain that his patient suffers from prostate carcinoma. With younger patients he would go for a chemotherapy, radiotherapy, or other therapeutic interventions. In this case, however, he feels that the negative side effects of a treatment[162] *would truly dominate. He thinks that with a non-treated carcinoma this patient could lead a "better life" than if he enters a treatment process. He asks the group: "What shall I tell my patient? What would you suggest to him?" The following discussion mirrors a spectrum of attitudes:*

[162] Among the most common ones the *Swiss Medical Board* (2011: 47) lists continuous incontinence, erectile dysfunction and intestinal impairment.

- *Either to ask an urologist for his opinion or to refer the patient to him right away. This produces the harsh reaction of another member who states that it is a family physician's job to make such decisions, and that they cannot simply be delegated to third parties.*
- *To conduct a local radiotherapy.*
- *To refrain from further actions that would possibly harm the patient and let him enjoy his life.*

So, this round of replies represents the negotiation about what, at that point in time, is the most important form of well-being. For some it is the attempt to regain physical health and to stop the carcinoma from growing further. For others it is sustaining the patient's perceived well-being and his „quality of life", as they call it. Despite the different answers, in the end the members of the group also stress that with an untreated prostate cancer the patient has a life expectancy of a few more years. Due to the fact that he does not suffer from any pain yet and seems to be in a good condition, they propose doing without treatment and thus support the doctor in his opinion. This goes along with official recommendations.[163] *Although this tallies the responsible physician's view with the view of the quality circle, it does not free him from the consultation with his patient. Even though he can rely on his colleagues' opinions and on the latest recommendations of the Swiss Medical Board, he still has to raise this sensitive issue in the consulting room, which makes him feel uneasy.*

With respect to this topic, the participants state that in medicine the pro-active treatments (such as various types of screening as well as preventive interventions) and the „destruction of the very first [cancer] cell" have replaced reactive treatment. One member stresses that as a doctor he is co-responsible for either saving his patients from or accompanying them on their entrance into these proactive „mills". (Fieldnotes, 23 November 2011)

These notes from this particular session aim at showing how multilayered such quality circle discussions can be, and how different epistemological reference systems and values come into play in making sense of a medical intervention. What these notes

[163] Swiss Medical Board (2011: 2f).

also illustrate, however, is how physicians find themselves stuck between their own ideas of a correct treatment, those which come from medical guidelines, and those entertained by patients.

In these meetings, self-reflection and external feedback therefore become intertwined (Gerlach et al. 1995: 1118). So, in these meetings physicians not only talk about what they are doing but also enter a collective process of reflection on how they are doing (or not doing) things. Schön, author of the famous book *The reflective practitioner*, writes:

> Through reflection, he [the professional] can surface and criticize the tacit understandings that have grown up around the repetitive experiences of a specialized practice, and can make new sense of the situations of uncertainty or uniqueness which he may allow himself to experience. (Schön 1993: 61)

The issues that are discussed in a quality circle meeting are manifold, and may touch different fields of practice, reaching from tacit to technical ones (cp. ibid.: 62), encompassing clinical issues, to administrative topics such as how to calculate tariff positions, and how reports are handled, to issues regarding physicians' well-being, such as experiences with burnout, frustration, or anger. At times external specialists are invited to share with the group the latest evidence in a specific clinical field. Such external inputs are then further discussed among the group members and linked to their individual clinical practice. Sometimes they decide to observe their behaviour in a specific area for a while and to take up the issue in one year's time to have a look at if and how their new knowledge has influenced their style of working. In this context many quality circles are active in conducting small-scale research, which they publish in local medical journals. Some quality circles build on thorough research activities and initiate larger research projects that may be conducted by university institutes of family medicine (Bally et al. 2009: 301).

In the quality circle meetings, comparative questions such as „Do you do this too?" are often raised. One interviewed family physician told me about his quality circle:

> I like this quality circle because […] ten or twelve people from the same background come together. We compare the experiences we've made. What do the others think about it, and what needs to be changed? Where do we really have to

> question ourselves? Is it really necessary that everyone suffering from a sinusitis receives antibiotics? (Dr Tanner)

Through the exchange and comparison of decisions made, the family physicians not only gained relief or security but also felt inspired or even gained new knowledge (Dr Kuhn, Dr Hauser). Interestingly, some physicians explained that such forms of self-reflection even influenced their decision-making trajectories in the absence of their colleagues (Dr Christen, Dr Berner).

7.5.4 Between trust and social control

However, the continuous formalization of quality circles increasingly produced criticism among family physicians. For instance, in a survey among a group of HMO practices, physicians were asked about their perception of quality circles. Respondents reported various difficulties, among them the difficulties in evaluating behaviour change and putting those evaluations into practice, and the mandatory participation that is perceived as de-motivating, because the format is implicitly used as an instrument of social control (Bally et al. 2009: 300f). Some of the physicians I interviewed struggled with similar constraints, eventually quitting their participation in quality circles due to tensions and competition within the group. One doctor recalls ironically:

> There's a quality circle [of a physician network] which appears a bit elitist. I joined but left again after three quality circle meetings. They were very upset and said that it would harm me as well as them […]. They behaved really [elitist]: "We are the ones. We are those physicians who adhere to the guidelines, and we work cost-efficiently […]." […] I felt that if someone lowers his guard he will immediately be red-lined. (Dr Ruch)

Another doctor describes his failed attempt to establish a quality circle in his valley:

> We [colleagues from the valley] tried but we couldn't really establish it. One time we discussed about how we handle driving-fitness certifications for the elderly. That was very good. We discussed who does it in which way. This made sense and was really profitable. Concerning other topics I perceive certain ideological differences with my colleagues. Presumably because they just treat in a different manner than I do. At best, quality circles have an effect like the one about handling those driving permits. At worst it's just another attempt to stand-

> ardise medical work. […] Furthermore, it's not so simple here [in the valley] because we not only work together but are also competitors. (Dr Hauser)

Both quotations express the need for having an "ideal" frame, in which "successful" collective self-reflection should take place. For many family physicians the constitution of the group, as well as a confidential atmosphere within the group, are thus decisive factors for peer-group meetings. In this context, trust is perceived as a space where honest and open talk is possible, that is, an exchange without the fear of social sanctions such as blame, exclusion by the group members, or embargos on referrals.

Yet, in a positive sense, the professional networks that are created and maintained through such groups are described as an intra-professional quality control. One doctor, for instance, notes:

> Well, there's a general agreement that in this job one shouldn't be alone. […] It's really something quite good to be around people whom one trusts. […] It's good if it [exchange] happens within structures. That one tries to establish a network with which one collaborates. […] To me quality emerges where I learn something. That's particularly the case in close contact with a quality circle or at a further-education meeting: When you really learn how someone else does something and receive ideas [about things] which you didn't know yet. (Dr Kuhn)

Accordingly, professional exchange in such groups also has some sort of intra-professional control function and thus represents one form of "social control" among physicians (Bosk 2003: 16), other than "formal-external controls" (ibid.: 21) such as those lamented by physicians due to health insurance companies. This less formal social control among physicians builds on mechanisms such as the creation and maintenance of a network of colleagues to collaborate with, the responsibility to talk about one's work in a group of peers, and the "supervision among colleagues" (Bahrs et al. 1993: 968, author's translation) which one doctor describes as follows:

> The original idea of quality circles is to rope in the autistic lone wolves who do strange things. […] And then, to put them in a circle and to let physicians regulate themselves among each other. Perhaps that's the best kind of quality assurance. (Dr Kuhn)

7.6 Medical fallibility's continuing legacies

Despite these global discussions on patient safety and the local attempts by family physicians to reduce errors and uncertainties, many family physicians still express a certain reluctance to discuss errors openly. They emphasise that no constructive culture of error exists that would accept mistakes as an inherent part of medical work, but rather one that considers mistakes as aberrant or abnormal. For instance, it was noted that the fear of legal sanctions following medical misconduct influences family physicians' working style:

> I think that in the meantime [compared to the past] one will be hit with a lawsuit when something goes wrong. […] That is why I made myself comfortable and don't get myself into hot water anymore. […] Nowadays I don't wish for too many complications and risks. I want to get by well, without suits and trouble. One becomes easy-going. I've left the "Sturm und Drang" days behind. (Dr Jakob)

> [Concerning patients whom the doctor has never seen before] the problem is merely – perhaps this anxiety isn't justified – that if someone came to me and I didn't understand his concerns and then he left: That's an incredibly annoying feeling. If he tells someone that he was at this doctor who didn't pay attention to something [to a symptom]. That's increasingly… One is increasingly afraid that something might happen, which could have legal consequences. This has increased enormously. At least the fear of it. I'm not so sure how realistic this is. (Dr Debrunner)

Especially the last two sentences point to the mechanisms through which patient safety is established and maintained as a regulatory concept, namely through the creation of an atmosphere of fear of sanctions. This illustrates a turning point, where the safety discourse is incorporated selectively by physicians and reproduced through technologies of the self. Therefore, similar to Holert's (2004: 244, author's translation) assumption that "security" is "omnipresent and self-evident", yet remains "rather an atmosphere than a state", the same could be said of sanctions in cases of compromised patient safety: Although real sanctions are probably rather rare, physicians act as if they were wide-spread, and accordingly they avoid them like the plague.

Aside from the fear of legal sanctions, family physicians describe an intrinsic ambivalence about the risk of making mistakes. To them, anxiety, uncertainty, and imperfection remain constant companions in medical practice. One doctor characterised this as an unavoidable working reality:

> Apart [from my self-expectations] there are always things which I don't consider, which I miss, which I forgot to ask. This comes up again and again, and that's not good. […] In such cases I've got a bad conscience. […] One isn't perfect. Nothing is 100%. (Dr Christen)

A bit later in the interview she added:

> I've got a niece who studied medicine and finished her studies last fall. […] She wondered how it's in practice […]. I told her that one notices that everyone puts his pants on one leg at a time. That one needn't have such high demands. […] That one can simply try it out, and that there's a *constant* [emphasised] fear of having forgotten something or having done something wrong. That this is an intrinsic issue [of medical work] and that it's difficult. It's what we buy with this job. I then noticed that she has […] an incredibly high self-expectation, aiming never to make any mistakes. I can only say that she gives herself a hard time. […] She's right, of course, it's about ethical expectations, about life and death, and we should really try to have people get well. […] But it [fallibility] remains an inherent issue, and it's difficult to cope with it. (Dr Christen)

In discussions of medical practice and decision-making, fallibility is generally accepted as an inevitable reality. Although patient-safety approaches aim at reducing and possibly preventing medical errors, it is agreed that error-free decision-making is not feasible. In their book *Managing uncertainty: ethnographic studies of illness, risk and the struggle for control* Richard Jenkins et al. stress that:

> Even allowing for an agreed diagnosis, there is rarely, if ever, just one obvious best thing to do […]. A degree of uncertainty is as intrinsic to these processes as it is to life itself. (Jenkins et al. 2005: 14)

This perspective indicates that the risk of error is, aside from human factors, grounded in the nature of medicine as such. Engelke (2008: S16) stresses that EBM, for example, "is not about certainty, but about a kind of 'certain reliability'". The systematic production of knowledge thus does not guarantee infallible care but main-

tains the "risk of making the wrong decision" (Kurtz 2002: 65, author's translation). As one doctor notes:

> [As a doctor] one must be willing to bear risks and to accompany someone at one's own risk that a decision perhaps needs to be revised. A decision which perhaps wasn't wrong but was not optimal, either. Errors happen, I've experienced this before. (Dr Sieber)

Such a standpoint implies that even when physicians have guidelines available, they do not discount their own reflections about how to proceed with treatment. Interviewed family physicians stressed that even though they do have tools at hand to assist them in making decisions, uncertainty remains an inseparable part of medical practice. Horton (1995b: 3) emphasises the continuous difficulty "that doctors must make decisions, give advice, and offer assistance based on limited interpretation of limited evidence". That is why additional types of knowledge and evidence which help physicians to make decisions remain an indispensable aspect of medical work.

Doctor Tanner | Comparing family medicine to mountaineering

Dr Tanner is 45 years old, married and has a 10 years old daughter. He has lived and worked in a rural mountain village for the past decade.

He is member in a regional quality circle and completed a moderation training. The quality circle arose out of the bad collaboration among Dr Tanner and other family doctors in the region. They did not know each other and perceived each other as competitors. The quality circle meetings helped to overcome these aversions and prejudices and led to a positive professional attitude towards each other. Additionally, for many years Dr Tanner has been visiting a psychiatrist with whom he discusses emotionally challenging cases or his own wellbeing. A smaller part of his patients live in a home for the elderly with an institutionalised ethical roundtable in which Dr Tanner regularly participates to discuss issues such as end-of-life decisions.

Dr Tanner describes himself as truly orientated towards natural science. However, he also expresses a strong interest in Narrative-based Medicine and in issues concerning professional experience and intuition. He considers himself as someone who is fond of storytelling.

To Dr Tanner, his job as a family doctor is very similar to mountaineering, which he feels most passionate about. In both domains, the calculation of risk, experience and training, taking on responsibility and the central role of intuition are crucial.

Dr Tanner likes to work under dire circumstances such as long working hours (60-90h per week), carrying full professional responsibility. That is why he preferred smaller hospitals during his educational years: here he could take on responsibility for his clinical decisions, whereas in the larger hospitals this would not have been the case. He worked in the fields of obstetrics, anesthesia, mountain medicine and mountain rescue. He was offered a practice in a busy mountain village ten years ago which he declined because his wife did not want to move there. Instead, he took over the practice he is currently working at. This was a very hard decision for him and was further complicated by the challenging village structures, the tough working conditions and financial concerns. As a consequence he suffered from a severe depression during the first years of establishing his practice and only slowly found back to per-

sonal well-being and professional satisfaction. Today Dr Tanner's practice counts about 1'500 patients. He regularly employs and teaches assistant doctors and has organised and structured the practice facilities in a "modern" and sustainable way (electronic patient records, large enough for double practice).

> In many fields, measurements, provided they are properly performed and safeguarded by experimenters, count as evidence. They are considered capable of proving or disproving theories, of suggesting new phenomena, of representing more or less interesting – and more or less publishable – "results". This view holds irrespective of the fact that measurements are theory-laden, prone to raise arguments in crucial cases, and sometimes subject to re-interpretation. Within the framework of their dependence on a certain paradigm and tradition, measurements count as self-sufficient quantities; they are granted a powerful role in validating knowledge, and they are considered irreplaceable as witnesses and arbiters in scientific disputes. (Knorr Cetina 1999: 53)

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8 Conclusion

8.1 Summary

The legal intervention of 1996 transformed medical quality matters from an intra-professional domain to a field of multiple expertise and negotiation. It culminates the change in status of the medical profession, because professional autonomy in this regard is replaced by control and administration of medicine shared with other actors and functional systems. That is why I consider 1996 as a caesura in family medicine, in the Foucaultian sense of disruption, discontinuity and transformation: It forced family medicine to institutionalise and externalise a certain kind of quality thinking and to participate in quality discussions with medical as well as non-medical actors. Therefore, 1996 initiated an ongoing re-mapping of family medicine that blurred the boundaries between intra- and extra-professional domains, and between State regulation and professional autonomy. It inevitably led to the re-framing of professional space and to the re-modelling of the notion of the "good physician". Quality-related

developments since 1996 have created a network of institutions, discourses, publications, practices, rhetorics, regulations, evaluations, and certifications that can be conceptualised as a *quality dispositive*.

In discussing the quality dispositive, I have focused on penetrating various kinds of discourse, such as a discourse about the economisation of family medicine, an epistemological discourse about evidence and patient-centeredness, and a discourse about patient safety and medical fallibility. As I have shown throughout these chapters, quality discourses are like an "endless and open strategic game" (Gordon 1991: 5) in which specific links between rationalities (knowledge) and technologies of conduct (power) are tied down and negotiated (Lemke 2000: 43).

8.2 Culmination at the point of quality measurement

All the discourses running through the quality dispositive culminate in one location, at one point: measurement. The measurement of quality represents a supremely powerful moment in these discourses because it determines how physicians' performance is controlled and eventually sanctioned:

> The official audit is the paradigm of formal-external control. Here, there is a regular, ongoing review of performance, standards of acceptable performance are set in advance on the basis of objective criteria, and negative sanctions are attached to failures to meet expectations. (Bosk 2003: 19)

The measurement of quality is based on a specific definition of both quality and care (Donabedian 1980: 3; 2005 (1966): 692, 704f). In this respect, quality assessments build on an essentialist idea of quality that can be measured and thus made visible (Strathern 2000a: 313). They depend on a specific notion of health that can be translated into quantitative language (Donald 2001: 431).

Even though mission statements on quality are generally very broad, quality remains a value to be transformed for handling and management, and therefore to be measured in a quantitative way. Reaching back to the 1970s, Parry's explanation for this focus still represents a simple but useful explanation of this methodological choice:

> Assessment presupposes standards, comparisons and consensus; in turn, some means have to be found for recording the activity under review in measurable terms. It is simpler to use quantitative than qualitative measures […]. (Parry 1975: 552)

The applied methodology thus produces knowledge for a specific use which Tsoukas (1997: 839) called "information", consisting "of objectified, decontextualized, timeless, impersonal, value-free representations to be used instrumentally". This instrumentalisation allows for the administration and control (ibid.: 831) of professional performance.

Today, even far more than in earlier quality discussions, statistics represent the frame in which the quality of medical performance is classified and reflected upon (cp. Hacking 1991). In this respect, quality measurement cannot be viewed in isolation but only in regard to its purpose, which is the comparison of physicians or practices against each other (benchmarking) and taking action in those cases where performances fail to meet average measures (sanctions). Thus, „standards always involve some sort of comparison" (Busch 2011: 57). In this respect, the assessment of quality is related to the attempt to standardise medical performance. With Hacking's (1991: 183) work in mind, one could say that a specific idea of normalcy forms a meta-concept of statistical quality control: In this sense, the aim of medical auditing is to define "the 'normal value' upon which all medical practice is based" (Williamson 1973: 706), even though it seems that current approaches omit the notion "normal" and prefer "standard" instead. Thus, performance is to be orientated towards standards so as to diminish variation "in process" and to reach "less and less difference between people" (Walton 1986: 92), one of the core concepts that medical actors adopted from Deming's work (Martin 1994: 211).

The applied techniques of producing visibility create a specific profile of the field under scrutiny, and are related to the assumption "that the things quantified are in fact the (only) relevant factors" (Busch 2011: 145). In a concept paper the *FMH*, for example, uses the illustration of a desk lamp which spotlights a statistical curve and a

pie chart (figures 4 and 5).[164] Around the cone of light there is darkness. From an anthropological perspective it is particularly this darkness (cp. Bowker & Leigh Star 2000: 321), the unknown or non-measured and non-measurable aspects that draw our attention, as well as the phenomenon of the lamp itself.

Figure 4: FMH quality spotlight 2010[165]

Figure 5: FMH quality spotlight 2012[166]

Tsoukas (1997: 831) notes that what "is measurable, standardizable, auditable is measured and is thought to stand for, to represent, the phenomenon at hand". Yet, quality measurement does not simply depict a specific "reality" but also in fact creates it (Koschorke 2004: 151 in Bröckling 2004a: 77f). This aspect of any figure-ground construction or perception is usually overlooked in the focused interests of what is being "seen." Yet any such construction is both limited and to a certain ex-

[164] S. also Tsoukas' notes on the "metaphor of light" that has been used since the era of the Enlightment to illustrate a specific type of knowledge used for improvement and control (Tsoukas 1997: 839).
[165] Nikolic & Herren (2010: 974).
[166] Nikolic (2012: 360).

tent arbitrary. Instead, it is presented as an image of a working reality (Rohde-Kampmann et al. 2007: 244). The foreword to the book *Stichwort: Qualitätsindikatoren*[167] for example begins with the message that quality indicators "are close to the truth" (Jonitz in Stock & Szecsenyi 2007: 7, author's translation). The production of transparency thus highlights certain aspects of medical work in a particular way but leaves many others aside, in the darkness surrounding the "truth" cone. Accordingly, critics note that aspects that are not made visible do not exist (Stoellger 2005: 981) and are thus "knowingly eclipsed" (Strathern 2000a: 309). A family physician whom I interviewed called this narrowed focus the "ostrich attitude":

> You search where there is light. […] It's no good developing guidelines, indicators, and rules only where the material is available. To enlarge the measurable – statistics, numbers […] – other criteria might be needed. (Dr Frei)

Transparency is thus created from a sum of collected fragments which are defined as "useful" (Tsoukas 1997: 828) and which are set into a specific relation to each other. In his article called *The tyranny of light*, Tsoukas (1997: 830) describes how this sum of collected information conceptualises a person who is regarded as "the sum total of his interactions with, and behaviours in, certain institutions". In an early article on the necessity of implementing quality control in medicine, Pflanz (1968: 1946, author's translation) stresses the necessity of replacing the ideal and romantic picture of medical work with an unemotional analysis of the "single stones of the mosaic of medical performance" as well as the total pattern of these stones. In the medical context, the fragmentation of medical work and the re-arrangement of it in the course of quality assessments produce a certain uneasiness among family physicians:

> I'm a bit scared that quality is increasingly measured in terms of these partial aspects […]. [For instance,] the health insurance companies have launched a campaign where they aim at observing how often one has prescribed nutrition counselling to the same patient in the past several years. (Dr Tanner)

This quotation refers to the power inherent in the production of transparency which Strathern (2000a: 310; emphasis in original) expresses with a crucial question, name-

[167] *English* Keyword: quality indicators.

ly "*What does visibility conceal?"* The set-up of indicators thus reflects a powerful choice about exclusion that people make, however unconsciously. To make this choice means to focus on specific aspects of specific sectors of medical work with the help of specific rationalities, data sets, and instruments that aim at producing "precise, […] objectified, abstract, decontextualised information" (Tsoukas 1997: 828), while ignoring other factors.

Even though there is general awareness of the fact that quality assessments cannot produce a complete image of medical performance but only fragments of it (Donabedian 1980: 5; Pflanz 1968: 1946ff), actors act as if this were of no concern (Strathern 2000a: 315). Thus, they do not consider this exclusion or invisibility factor as reason enough to abandon quality assessments, but instead stick to the conviction that it remains a necessity and invest even larger resources in further developing tools used for the reification and assessment of medical performance. Most often these tools run along the channels of Donabedian's three quality dimensions of structure, process and outcome (Donabedian 2003: 46f). In his view, these three dimensions form a "chain of events in which each event is an end to the one that comes before it and a necessary condition to the one that follows" (ibid. 1966: 713). The endpoint of this causal chain is the outcome. Donabedian, and many others up to the present, have been well aware of the difficulty of defining a quality outcome. Although Donabedian emphasised that "quality […] is not represented by health status" (ibid. 1980: 10), health status – along with related terms such as life expectancy, mortality and morbidity, degree of disability, or DALY[168] – still represents a crucial outcome category in current quality programs. For instance, from the time of earlier quality assessments (Froom 1976) until present-day ones, data on morbidity and mortality has been used to assess performance and thus to decide about outcome quality. Eric Cassell holds a critical perspective toward this (s. also Epstein 2009: 40):

> Survival, while simple to measure, is a poor indication of the quality of care. […] Measuring the quality of medical care predominately by heartbeats and

[168] Disability-adjusted life years.

> body heat is one of the reasons modern medicine got into its current difficulties – focused more on diseased organs and technology than on the goals of sick persons. Patients do not simply want to survive, they want to survive in order to live a life in which they can recognize themselves and in which their values are preserved. (Cassell 1997: 130)

Cassell, here, strongly criticises the narrow idea of quality expressed by such outcome measures. Against this background, the operationalisation of a specific quality notion is not a trivial matter but in fact a powerful one: Quality assessment is the linking and decisive element between quality definitions and quality sanctions. The choice of standards, indicators and items is important (Koschorke 2004: 151 in Bröckling 2004a: 77f; Hacking 1991: 181), because that choice draws the line between what is considered as "best practice" and what is not. That is why Strathern (2000a: 309) concludes that "there is nothing innocent about making the invisible visible".

Sanctions, not yet institutionalised in Switzerland, are limited to health care systems such as the British *NHS*, where quality indicators are applied as instruments which determine a family physician's salary. Referring to this context, Contencin et al. (2006: 65) note that "up to a third of a practice's income can depend on performance as judged by score points for quality indicators". Indicators are thus not neutral instruments of measurement but means of regulation. When talking about British colleagues, an interviewed family physician comments:

> If you have more than 40% of smoking patients you will get a drawback [of your salary]. And if you have more than 70% of non-smoking patients, you get a bonus. In one year this will be controlled again. If you have improved you will again get a bonus, and vice versa. And to me this is not the optimum. […] Is a smoker an insufficiently treated patient with a bad family physician, or is he someone who has decided on wanting to smoke? (Dr Kuhn)

This example illustrates why the different actors dispute the operationalisation of quality concepts into indicators: It is particularly the open question of sanctions based on those indicators that creates unease among family physicians.

8.3 Avoidance of a second caesura

Having said this, one must observe that the external measurement and control of quality would represent a second caesura for Swiss family medicine, which professional associations try to accommodate themselves to with a lot of resources, proactive programs to enhance "transparency", the intra-professional development of quality indicators (Ramstein & Schneider 2009) and an enhanced quality rhetoric to establish the measurable fact that physicians are somehow, in spite of various incommensurables, performing quality control.[169] Thus, they do not oppose quality control but instead unanimously advocate regulating it intra-professionally. In this respect, quality activities and measures are regarded as an inevitable resource for the maintenance of the professional future. For instance, the former president of *EQUAM* stresses the importance of quality certifications for the future positioning of physicians and their networks:

> EQUAM-certificated practices and physician networks have a future. To externals they prove in a visible and transparent manner that they practice a quality culture in daily life and are willing to confront the quality dialogue. With this, they are perfectly equipped for the requests for quality assurance, however they may turn out. (Sommaruga 2010: 3, author's translation)

Another example relates to the plan of the *FMH* to proactively establish an institute in which the requested quality indicators would be developed intra-professionally so that, it is hoped for, external quality measurement becomes obsolete. The interviewed head of the FMH-section DDQ explains that "[t]here exists a concept to develop a proper medical quality organisation […]. The idea is that it can later cooperate with the national Q-Institute […]". „The idea is that one day", she continues, „one won't get around the planned quality institute of the medical fraternity anymore". From this perspective, quality is regarded as an indispensable instrument for future competition among various actor groups (Kälble 2005: 10). This is visible, for

[169] Although family medicine has proven to be receptive to the modern quality rationale, it has never agreed to being assessed by external actors with extra-professional quality criteria (e.g. Parry 1975: 552; Jeffs 1973: 689; Aeffner 1968: 618; Pflanz 1968: 1948; Berry et al. 2006: 1601; Fassl 1977: 517f).

instance, in the emphasis placed upon, and resources spent on, quality control in HMO practices. In this context, the medical associations perpetuate the modern quality rationale further and thus keep reproducing the same rationale. Although this activism comes from the professional associations, it remains an open question, as to if and how family physicians will cooperate with these claims for a kind of intra-professional quality control that is translatable into indicators, numbers and benchmarks. The interviewed physicians doubt that the multilayeredness of professional performance can be objectified, and are afraid of mandatory quality activities that would not touch their working lives (cp. Strathern 2000a: 314). In this light, it will be interesting to follow the process during which the professional associations will try to win over family physicians to their quality plans. Until now this has proceeded voluntarily, for instance through the establishment of a "Quality award" which aims at stimulating a feeling of intra-professional competition in terms of quality activities. Yet, the interviewed family physicians expressed their absence of motivation for quality certifications and quality activities reaching beyond peer-group meetings and CME, viewing these as having no benefit for their daily performance. For instance, one interviewed doctor explained her ambiguity on this matter as follows:

> I think that they [current quality discussions] are right. […] It's the spirit of the time, something needs to happen. I'm absolutely against the maintenance of the "demigod in white". But a lot of people who, so I think, don't see into our daily life, are talking about it [quality]. And to us this is quite frustrating. It's out of the question that this work should be measurable in some way. […] I don't mean to criticise all that. But in the extreme case when [for instance] patient groups talk in isolation about the quality of physicians… And physicians want to present their quality as well as possible… I doubt that this would sincerely influence the concrete options of care or the concrete work of a doctor. (Dr Christen)

The demand for the creation of transparency has created a new kind of required expertise, that of auditors and quality experts. In the context of family medicine this new expertise is represented by evaluation institutes and their quality experts who show actors, or more precisely physicians, "how to manage themselves more successfully" (Gershon 2011: 542). Through the production of new "specialist knowledge", however, a gap widens between experts and "lay people" (Stehr &

Wallner 2010: 14f), which might result in a discrepancy between the view of observers and that of physicians (Tsoukas 1997: 834; Stoellger 2005: 982). One of my interviewed physicians expresses his sense of this gap in the following way:

> Those institutions that certify quality are self-designated wannabes. They have decided all of a sudden that they are going to be quality experts. Well, I've got problems with that. How is quality measured in the practice? Who measures quality in the practice? These are difficult questions. An [evaluation] institution that manages to establish a certain kind of quality measurement which is introduced as mandatory, and over which the institution holds exclusive executive power, is untouchable. That's how it works, and I don't like that at all. (Dr Escher)

In contrast to their critical view of quality programs, which they perceive as removed from daily practice, family physicians told me about a general need for external feedback. Two physicians, for instance, recount:

> It's really incredible how much we have to decide on our own how we want to do something. You're delivered to the wild and can principally do whatever you want. That's incredible. Certainly we don't always do things in a good way, and there we are left relatively alone. (Dr Notter)

> I've got to judge my work and quality myself, but I wish for a higher authority that collects data from x practices and which tells me: "Look, you do it like the others, or rather a bit differently. Neither good nor bad, but that's simply the fact." Unfortunately, this doesn't happen at all. (Dr Quinn)

As I have shown in this study, the modern quality rationale began its journey in the industrial sector, later caught the interest of global medical associations and was declared as a federal and thus external request in the Swiss health-care system as recently as 1996. Current discussions and actions show that the medical associations try to hold onto their dissolving professional boundaries even though medicine has become a field of multiple actors. Against this background, the control of medical quality is apparently seen as one of the last trump cards in the deck.

One interview partner noted that the Swiss health-care system is heading toward a storm in which a lot of "question marks and uncertainties" (Dr Odermatt) will prevail. In this context, 1996 forced family physicians into intra-professional debates

about the meaning of quality and, consequently, about the profession itself. No one has formulated this shift as precisely as Greenhalgh in her book *Primary Health Care: Theory and Practice*:

> The shift from an "internal" view of professionalism (based on the person's commitment to professional values and codes) to an 'external' one (based on accountability to the state and the public, and the implementation of formally agreed, approved and measurable standards, as in – but not restricted to – clinical governance) also reflects a very different theoretical model of 'the good clinician' (and incidentally, a philosophical shift from humanism to objectivism […]). […] The underlying philosophical difference here in the nature of 'goodness' […] is between professionalism as a virtue (embracing, e.g. integrity, commitment and altruism, which like all virtues, can only be measured indirectly), and professionalism as performance (e.g. "maintains confidentiality", "prescribes controlled drugs responsibly" and so on, which can be measured directly). The tension between a humanistic (virtue-based) definition of professionalism and an objectivist or behaviourist (performance-based) one lies at the heart of the stormy debates currently raging about how to teach (and assess) professionalism in both medicine and nursing. (Greenhalgh 2007: 140)

Yet, as the history of family medicine shows, the profession has always been on the move and has adapted to societal as well as technological transformations. Leading figures such as Eric Cassells, Barbara Starfield, Trisha Greenhalgh, Douglas Fleming and D. Crombie, Hannes Pauli, Georges Canguilhem, Michel Balint, Rolf Adler, or George Engel, just to name a few, have continuously introduced new approaches and perspectives to family medicine. Although Feldman (2004: 708) notes that quantification and objectification of knowledge result in a „loss of […] organizational memory", what is currently happening is a transformation rather than a loss. A doctor expressed this as follows:

> Now we have to work in a really difficult frame, and it won't turn better. For five years now, it [working conditions] has been getting tighter, and it becomes increasingly difficult to move inside this frame. This requires a stronger philosophy of life which is based upon satisfaction. Upon what I'm well at, and who I work well with. It's not just about functioning but about working with satisfaction. But that's quality too: If you manage that, you'll work better. (Dr Quinn)

The *Taylor report* (Taylor 1954: 445, 555) emphasised that only physicians themselves can decide on their professional future. This has definitely changed and so it remains open how family physicians will cope with this re-mapping of their professional space. In this respect, although the "family physician" will certainly not die, that role will be transformed. In the course of this transformation, the main challenge for the medical fraternities will perhaps be to refrain from manoeuvring themselves proactively – in an attempt to avoid an external "audit explosion" (Power 1994) – into an "audit implosion" (ibid. 1999).

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